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103D CONGRESS
2D SESSION

# H. R. 150

To amend the Internal Revenue Code of 1986 to improve access to health care, and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

Mr. HASTERT (for himself, Mr. GOSS and Ms. FOWLER) introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, and the Judiciary

JANUARY 27, 1994

Additional sponsors: Mr. GALLEGLY, Mr. BAKER of Louisiana, Mr. HERGER, Mr. COX, Mr. SUNDQUIST, Mr. EMERSON, Mr. KYL, Mr. MACHTLEY, Mr. MCKEON, Mr. LEWIS of Florida, Mr. SENSENBRENNER, Mr. ZELIFF, Mr. KINGSTON, and Mr. BALLENGER

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# A BILL

To amend the Internal Revenue Code of 1986 to improve access to health care, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Choice and Access Improvement Act of 1993''.

(b) TABLE OF CONTENTS.—

# TITLE I—FAMILY HEALTH AND WELLNESS SAVINGS PLAN

**SEC. 101. MEDICAL SAVINGS ACCOUNTS.**

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

**''SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

''(a) DEDUCTION ALLOWED.—In the case of an eligible individual, there shall be allowed as a deduction amounts paid in cash during the taxable year by or on behalf of such individual to a medical savings account.

''(b) LIMITATION.—

''(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the excess (if any) of—

''(A) the lesser of—

''(i) the applicable limit, or

''(ii) the compensation (as defined in section 219(f)) includible in the individual's gross income for the taxable year, over

''(B) the sum of—

''(i) the value of employer-provided coverage for the medical expenses of such individual,

''(ii) the amount paid by the individual (other than from amounts distributed from a medical savings account) for coverage under qualified catastrophic coverage health plan for coverage for such individual, the spouse of such individual, and dependents (as defined in section 152) of such individual, plus

''(iii) the aggregate amount contributed to such account during the taxable year pursuant to section 125(d)(3).

''(2) APPLICABLE LIMIT.—For purposes of paragraph (1), the applicable limit is the sum of—

''(A) $4,800, plus

''(B) $600 for each individual who is a dependent (as defined in section 152) of the individual for whose benefit the account is established.

''(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the individual for whose benefit the trust is established, but only if the written governing instrument creating the trust meets the following requirements:

''(A) No contribution will be accepted unless it is in cash and contributions will not be accepted for any taxable year in excess of the applicable limit (as defined in subsection (b)(2)).

''(B) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will ad-

minister the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any individual if—

''(A) such individual is not covered by any employer-provided group health plan, or

''(B) such individual is covered by an employer-provided group health plan which is a qualified catastrophic coverage health plan and is not covered by any other health plan.

''(3) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means—

''(i) medical expenses, and

''(ii) amounts paid for qualified long-term care insurance (as defined in section 818(g)).

''(B) MEDICAL EXPENSES.—The term 'medical expenses' means amounts paid by the

individual for whose benefit the account was established for medical care (as defined in section 213) of such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(4) QUALIFIED CATASTROPHIC COVERAGE HEALTH PLAN.—The term 'qualified catastrophic coverage health plan' means any health plan which is certified by the Secretary of Health and Human Services as a plan—

''(A) which provides no compensation for medical expenses not exceeding $3,000 during any year,

''(B) which requires the individual to pay 15 percent of such individual's medical expenses to the extent they exceed $3,000 but not $9,000 during any year, and

''(C) which provides full reimbursement for medical expenses exceeding $9,000.

''(5) TIME WHEN CONTRIBUTIONS DEEMED MADE.—A taxpayer shall be deemed to have made a contribution on the last day of the preceding taxable year if the contribution is made on account of such

taxable year and is made not later than the time prescribed by law for filing the return for such taxable year (not including extensions thereof).

''(d) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, any amount paid or distributed out of a medical savings account shall be included in the gross income of the individual for whose benefit such account was established unless such amount is used exclusively to pay the qualified medical expenses of such individual.

''(2) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a medical savings account to the extent that such contribution exceeds the amount allowable as a deduction under subsection (a) if—

''(A) such distribution is received on or before the day prescribed by law (including extensions of time) for filing such individual's return for such taxable year,

''(B) no deduction is allowed under subsection (a) with respect to such excess contribution, and

''(C) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (C) shall be included in the gross income of the individual for the taxable year in which it is received.

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) EXEMPTION FROM TAX.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to be an investment savings account by reason of paragraph (2). Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) LOSS OF EXEMPTION OF ACCOUNT WHERE INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

''(A) IN GENERAL.—If, during any taxable year of the individual for whose benefit the medical savings account was established, such individual engages in any transaction prohibited by section 4975 with respect to the account, the account ceases to be a medical savings account as of the first day of that taxable year.

''(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (d) applies as if there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day).

''(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a medical savings account was established uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed to that individual.

''(f) ADDITIONAL TAX ON CERTAIN AMOUNTS INCLUDED IN GROSS INCOME.—

''(1) DISTRIBUTION NOT USED FOR QUALIFIED MEDICAL EXPENSES.—If a distribution from a medical savings account is made, and not used to pay the qualified medical expenses of the individual for whose benefit the account was established, the tax liability of such individual for the taxable year in which such distribution is received shall be increased by an amount equal to 10 percent of the amount of

the distribution which is includible in gross income for such taxable year.

''(2) DISQUALIFICATION CASES.—If an amount is includible in the gross income of an individual for a taxable year under subsection (e), his tax under this chapter for such taxable year shall be increased by an amount equal to 10 percent of such amount includible in his gross income.

''(3) DISABILITY OR DEATH CASES.—Paragraphs (1) and (2) do not apply if the payment or distribution is made after the individual for whose benefit the medical savings account was established becomes disabled within the meaning of section 72(m)(7) or dies.

''(g) SPECIAL RULES.—

''(1) COMMUNITY PROPERTY LAWS.—This section shall be applied without regard to any community property laws.

''(2) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

''(A) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which

he will administer the account will be consistent with the requirements of this section, and

''(B) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (c).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(3) DENIAL OF DEDUCTIONS.—No amount paid or distributed from a medical savings account shall be taken into account in determining the deduction provided by section 213.

''(h) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, each applicable dollar amount shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment for the calendar year in which the taxable year begins.

''(2) COST-OF-LIVING ADJUSTMENT.—For purposes of paragraph (1), the cost-of-living adjustment

for any calendar year is the percentage (if any) by which—

''(A) the deemed average total wages (as defined in section 209(k) of the Social Security Act) for the preceding calendar year, exceeds

''(B) the deemed average total wages (as so defined) for calendar year 1992.

''(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1), the term 'applicable dollar amount' means—

''(A) the $4,800 and $600 amounts in subsection (b), and

''(B) the $3,000 and $9,000 amounts in subsection (c)(4).

''(4) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10 (or, if such amount is a multiple of $5 and not of $10, such amount shall be rounded to the next highest multiple of $10).

''(i) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may

require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) DEDUCTION ALLOWED IN ARRIVING AT ADJUSTED GROSS INCOME.—Paragraph (7) of section 62(a) of such Code (relating to retirement savings) is amended—

(1) by inserting ''OR MEDICAL EXPENSE'' after ''RETIREMENT'' in the heading of such paragraph, and

(2) by inserting before the period at the end thereof the following: ''and the deduction allowed by section 220 (relating to deduction of certain payments to medical savings accounts)''.

(c) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(c)),'',

(3) by striking ''or'' at the end of paragraph (1) of subsection (a), and

(4) by adding at the end thereof the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account, the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount allowable as a deduction under section 220 for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical savings account and a distribution to which section 220(d)(2) applies shall be treated as an amount not contributed.''

(d) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to prohibited transactions) is amended—

(1) by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2)(A) to such account.'', and

(2) by inserting ''or a medical savings account described in section 220(c)'' in subsection (e)(1) after ''described in section 408(a)''.

(e) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(1) by inserting ''**OR ON MEDICAL SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(2) by adding at the end of subsection (a) the following: ''The person required by section 220(i) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it

is shown that such failure is due to reasonable cause.''

(f) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the item relating to section 220 and inserting the following:

''Sec. 220. Medical savings accounts.
''Sec. 221. Cross reference.''

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4973 and inserting the following:

''Sec. 4973. Tax on excess contributions to individual retirement accounts, medical savings accounts, certain 403(b) contracts, and certain individual retirement annuities.''

(3) The table of sections for subchapter B of chapter 68 of such Code is amended by inserting ''or on medical savings accounts'' after ''annuities'' in the item relating to section 6693.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

**SEC. 102. UNUSED AMOUNTS IN FLEXIBLE SPENDING ACCOUNTS TRANSFERABLE TO MEDICAL SAVINGS ACCOUNTS.**

(a) IN GENERAL.—Subsection (d) of section 125 of the Internal Revenue Code of 1986 (relating to cafeteria

plans) is amended by adding at the end thereof the following new paragraph:

''(3) UNUSED AMOUNTS TRANSFERABLE TO MEDICAL SAVINGS ACCOUNTS.—

''(A) IN GENERAL.—Subsection (a) shall not fail to apply to a participant in a plan, and a plan shall not fail to be treated as a cafeteria plan, solely because under the plan amounts not paid out as reimbursements under a flexible spending arrangement for health and disability for the benefit of an individual are contributed to a medical savings account (as defined in section 220(c)) for the benefit of such individual.

''(B) SPECIAL RULES.—

''(i) TIMING OF CONTRIBUTIONS.—Contributions made under this paragraph shall be made on the last day of the plan year of the cafeteria plan.

''(ii) AVAILABILITY REQUIREMENT.—Subparagraph (A) shall apply only if the plan is available to at least 80 percent of the employees of the employer. For purposes of the preceding sentence, there shall be excluded employees who are excluded under section 414(q)(8) or who would be

so excluded if '30' were substituted for '17½' in subparagraph (B) thereof.''

(b) TREATMENT OF AMOUNTS RECEIVED BY QUALIFIED CASH OR DEFERRED ARRANGEMENT.—

(1) Paragraph (2) of section 401(k) of such Code is amended by striking ''and'' at the end of subparagraph (C), by striking the period at the end of subparagraph (D) and inserting '', and'', and by adding at the end thereof the following new subparagraph:

''(E) which provides that, with respect to amounts held by the trust which are attributable to contributions made to the trust pursuant to section 125(d)(3)—

''(i) an employee's right to such amounts is nonforfeitable, and

''(ii) such amounts may be used only to pay expenses (not compensated for by insurance or otherwise) for the medical care (as defined in section 213) of the employee, the spouse of the employee, or any dependent (as defined in section 152) of the employee.''

(2) Subsection (k) of section 401 of such Code is amended by adding at the end thereof the following new paragraph:

''(11) TREATMENT OF AMOUNTS RECEIVED FROM MEDICAL SAVINGS ARRANGEMENTS.—Contributions made to a trust by reason of section 125(d)(3) shall not be taken into account under paragraph (3)(A)(ii), and subsection (l) shall not apply to such contributions.''

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1992.

**SEC. 103. DEDUCTION FOR AMOUNTS PAID FOR QUALIFIED CATASTROPHIC COVERAGE HEALTH PLAN.**

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended adding at the end thereof the following new subsection:

''(g) FULL DEDUCTION FOR AMOUNTS PAID FOR QUALIFIED CATASTROPHIC COVERAGE HEALTH PLANS.—In the case of amounts paid for coverage under a qualified catastrophic coverage health plan (as defined in section 220(c))—

''(1) subsection (a) shall be applied without regard to the limitation based on adjusted gross income, and

''(2) such amounts shall not be taken into account in determining whether any other amounts are allowable as a deduction under this section.''

(b) TECHNICAL AMENDMENT.—Paragraph (2) of section 162(l) of such Code is amended by adding at the end thereof the following new subparagraph:

''(C) QUALIFIED CATASTROPHIC COVERAGE.—Paragraph (1) shall not apply to any amount allowed as a deduction under section 213 for amounts paid for coverage under a qualified catastrophic coverage health plan (as defined in section 220(c)).''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

# TITLE II—TAX TREATMENT OF LONG-TERM CARE INSURANCE AND PLANS

## Subtitle A—Treatment of Long-Term Care Insurance

### SEC. 201. QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT AND HEALTH INSURANCE FOR PURPOSES OF TAXATION OF LIFE INSURANCE COMPANIES.

(a) IN GENERAL.—Section 818 of the Internal Revenue Code of 1986 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT OR HEALTH INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to accident or health insurance shall be treated as including a reference to qualified long-term care insurance.

''(2) QUALIFIED LONG-TERM CARE INSURANCE.—For purposes of this subsection—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the term 'qualified long-term care insurance' means insurance under a policy or rider, which is issued by a qualified is-

suer, which meets standards at least as stringent as those set forth in the January 1990 Long-Term Care Insurance Model Regulation of the National Association of Insurance Commissioners, and which is certified by the Secretary of Health and Human Services (in accordance with procedures similar to the procedures prescribed in section 1882 of the Social Security Act (42 U.S.C. 1385ss) used in the certification of medicare supplemental policies (as defined in subsection (g)(1) of such section)) to be advertised, marketed, offered, or designed to provide coverage—

''(i) for not less than 12 consecutive months for each covered person who has attained age 50,

''(ii) on an expense incurred, indemnity, or prepaid basis,

''(iii) for 1 or more medically necessary, diagnostic services, preventive services, therapeutic services, rehabilitation services, maintenance services, or personal care services, and

''(iv) provided in a setting other than an acute care unit of a hospital.

The requirement of clause (iv) shall be met only if at least 1 of the settings in which such coverage is provided is the patient's home.

''(B) COVERAGE SPECIFICALLY EXCLUDED.—Such term does not include any insurance under any policy or rider which is offered primarily to provide any combination of the following kinds of coverage:

''(i) Basic Medicare supplement coverage.

''(ii) Basic hospital-based acute care expense coverage.

''(iii) Basic medical-surgical expense coverage.

''(iv) Hospital confinement indemnity coverage.

''(v) Major medical expense coverage.

''(vi) Disability income protection coverage.

''(vii) Accident only coverage.

''(viii) Specified disease coverage.

''(ix) Specified accident coverage.

''(x) Limited benefit health coverage.

''(C) QUALIFIED ISSUER.—For purposes of subparagraph (A), the term 'qualified issuer' means any of the following:

''(i) Private insurance company.

''(ii) Fraternal benefit society.

''(iii) Nonprofit health corporation.

''(iv) Nonprofit hospital corporation.

''(v) Nonprofit medical service corporation.

''(vi) Prepaid health plan.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1992.

**SEC. 202. QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT AND HEALTH INSURANCE FOR PURPOSES OF EXCLUSION FOR BENEFITS RECEIVED UNDER SUCH INSURANCE AND FOR EMPLOYER CONTRIBUTIONS FOR SUCH INSURANCE.**

(a) IN GENERAL.—Section 105 of the Internal Revenue Code of 1986 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(j) SPECIAL RULES RELATING TO QUALIFIED LONG-TERM CARE INSURANCE.—For purposes of section 104, this section, and section 106—

''(1) BENEFITS TREATED AS PAYABLE FOR SICKNESS, ETC.—Any benefit received through qualified long-term care insurance (as defined in section 818(g)) shall be treated as received for personal injuries or sickness.

''(2) EXPENSES FOR WHICH REIMBURSEMENT PROVIDED UNDER QUALIFIED LONG-TERM CARE INSURANCE TREATED AS INCURRED FOR MEDICAL CARE.—Expenses incurred by a taxpayer for which reimbursement is paid through qualified long-term care insurance (as so defined) shall be treated for purposes of subsection (b) as incurred for medical care (as defined in section 213(d)).

''(3) REFERENCES TO ACCIDENT AND HEALTH PLANS.—Any reference to an accident or health plan shall be treated as including a reference to a plan providing qualified long-term care insurance.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1992.

**SEC. 203. EXCLUSION FROM GROSS INCOME FOR AMOUNTS WITHDRAWN FROM INDIVIDUAL RETIREMENT PLANS OR 401(k) PLANS FOR QUALIFIED LONG-TERM CARE INSURANCE.**

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 136 as section 137 and by inserting after section 135 the following new section:

**"SEC. 136. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT ACCOUNTS AND SECTION 401(k) PLANS FOR QUALIFIED LONG-TERM CARE INSURANCE.**

''(a) GENERAL RULE.—The amount includible in the gross income of an individual for the taxable year by reason of qualified distributions during such taxable year shall not exceed the excess of—

''(1) the amount which would (but for this section) be so includible by reason of such distributions, over

''(2) the aggregate premiums paid by such individual during such taxable year for any policy of qualified long-term care insurance (as defined in section 818(g)) for the benefit of such individual or the spouse of such individual.

''(b) QUALIFIED DISTRIBUTION.—For purposes of this section, the term 'qualified distribution' means any

distribution to an individual from an individual retirement account or a section 401(k) plan if such individual has attained age 59½ on or before the date of the distribution (and, in the case of a distribution used to pay premiums for the benefit of the spouse of such individual, such spouse has attained age 59½ on or before the date of the distribution).

''(c) DEFINITIONS.—For purposes of this section—

''(1) INDIVIDUAL RETIREMENT ACCOUNT.—The term 'individual retirement account' has the meaning given such term by section 408(a).

''(2) SECTION 401(k) PLAN.—The term 'section 401(k) plan' means any employer plan which meets the requirements of section 401(a) and which includes a qualified cash or deferred arrangement (as defined in section 401(k)).

''(d) SPECIAL RULES FOR SECTION 401(k) PLANS.—

''(1) WITHDRAWALS CANNOT EXCEED ELECTIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR DEFERRED ARRANGEMENT.—This section shall not apply to any distribution from a section 401(k) plan to the extent the aggregate amount of such distributions for the use described in subsection (a) exceeds the aggregate employer contributions made pursuant to the employee's election under section 401(k)(2).

''(2) WITHDRAWALS NOT TO CAUSE DISQUALIFICATION.—A plan shall not be treated as failing to satisfy the requirements of section 401, and an arrangement shall not be treated as failing to be a qualified cash or deferred arrangement (as defined in section 401(k)(2)), merely because under the plan or arrangement distributions are permitted which are excludable from gross income by reason of this section.''

(b) CONFORMING AMENDMENTS.—

(1) Section 401(k) of such Code is amended by adding at the end the following new paragraph:

''(11) CROSS REFERENCE.—

**"For provision permitting tax-free withdrawals for payment of long-term care premiums, see section 136."**

(2) Section 408(d) of such Code is amended by adding at the end the following new paragraph:

''(8) CROSS REFERENCE.—

**"For provision permitting tax-free withdrawals from individual retirement accounts for payment of long-term care premiums, see section 136."**

(3) The table of sections for such part III is amended by striking the last item and inserting the following new items:

''Sec. 136. Distributions from individual retirement accounts and section 401(k) plans for qualified long-term care insurance.

''Sec. 137. Cross references to other Acts.''

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1992.

**SEC. 204. EXCHANGE OF LIFE INSURANCE POLICY FOR QUALIFIED LONG-TERM CARE POLICY NOT TAXABLE.**

(a) IN GENERAL.—Subsection (a) of section 1035 of the Internal Revenue Code of 1986 (relating to certain exchanges of insurance policies) is amended by striking the period at the end of paragraph (3) and inserting ''; or'' and by adding at the end the following new paragraph:

''(4) in the case of an individual who has attained age 59½, a contract of life insurance or a contract of endowment insurance or an annuity contract for a contract of qualified long-term care insurance (as defined in section 818(g)) for the benefit of such individual or the spouse of such individual if such spouse has attained age 59½ on or before the date of the exchange.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1992.

# Subtitle B—Employer Funding of Medical Benefits

## SEC. 211. MEDICAL BENEFITS FOR RETIRED EMPLOYEES AND THEIR SPOUSES AND DEPENDENTS.

(a) IN GENERAL.—Section 401(h) of the Internal Revenue Code of 1986 (relating to medical, etc., benefits for retired employees and their spouses and dependents) is amended to read as follows:

''(h) RETIREE HEALTH ACCOUNTS.—

''(1) GENERAL RULE.—Under regulations prescribed by the Secretary, a defined benefit plan may establish and maintain a separate health benefits account for the payment of medical benefits of retired employees and their spouses and dependents.

''(2) SEPARATE ACCOUNTING REQUIRED.—An employer establishing a health benefits account shall maintain separate accounts within the health benefits account for funded reserve accounts established under section 420A.

''(3) USE OF ASSETS.—Subject to the provisions of part III of this subchapter, the corpus or income of a health benefits account shall not be used for, or diverted to, any purpose other than providing medical benefits to retired employees and their spouses and dependents.

''(4) KEY EMPLOYEES.—

''(A) IN GENERAL.—In the case of an employee who is a key employee—

''(i) a separate account shall be established and maintained for medical benefits payable to such employee (and the employee's spouse or dependents), and

''(ii) medical benefits of such employee, spouse, or dependents which are attributable to plan years beginning after March 31, 1984, for which the employee is a key employee may be payable only from such account.

''(B) KEY EMPLOYEE.—For purposes of subparagraph (A), the term 'key employee' means any employee who, at any time during the plan year or any preceding plan year during which contributions were made on behalf of such employee, is or was a key employee (as defined in section 416(i)).

''(5) APPLICABLE RULES.—For rules applicable to health benefits accounts, see subpart F of this part (sec. 420A et seq.).''

(b) CONFORMING AMENDMENT.—Section 415(l)(2) of such Code (relating to treatment of certain medical ben-

efits) is amended by inserting ''by reason of section 401(h)(4)'' after ''dependents'' in subparagraph (B).

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to years beginning after December 31, 1992.

(2) TRANSITION RULE.—In the case of—

(A) a plan other than a defined benefit plan, or

(B) a defined benefit plan which elects, at such time and in such manner as the Secretary of the Treasury or his delegate may prescribe, to have this paragraph apply,

which on or before the date of the enactment of this Act established an account to which section 401(h) of the Internal Revenue Code of 1986 (as in effect before the amendments made by this section) applied (and which is in existence on such date), the amendments made by this section shall not apply to such account.

**SEC. 212. TREATMENT OF HEALTH BENEFITS ACCOUNTS.**

(a) IN GENERAL.—Part I of subchapter D of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subpart:

**''Subpart F—Treatment of Health Benefits Accounts**



**''SEC. 420A. DEDUCTION FOR EMPLOYER CONTRIBUTIONS TO HEALTH BENEFITS ACCOUNTS.**

''(a) GENERAL RULE.—Amounts paid by an employer to a defined benefit plan which are allocated to a health benefits account—

''(1) shall not be allowed as a deduction under this chapter, but

''(2) if they would otherwise be deductible, shall be allowed as a deduction under this section for the taxable year in which paid.

''(b) LIMITATION.—The amount of the deduction allowable under subsection (a)(2) for any taxable year shall not exceed the health benefits account's qualified cost for the taxable year.

''(c) QUALIFIED COST.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified cost' means, with respect to any taxable year, the sum of—

''(A) the qualified direct cost for such taxable year, plus

''(B) subject to the limitation of section 420B(b), any addition to the funded reserve account established under section 420B.

''(2) QUALIFIED DIRECT COST.—

''(A) IN GENERAL.—The term 'qualified direct cost' means, with respect to any taxable year, the aggregate amount (including administrative expenses) which would have been allowable as a deduction to the employer with respect to the qualified section 401(h) medical benefits provided through the health benefits account during the taxable year if—

''(i) such benefits were provided directly by the employer, and

''(ii) the employer used the cash receipts and disbursements method of accounting.

''(B) TIME WHEN BENEFITS PROVIDED.—For purposes of subparagraph (A), a benefit shall be treated as provided when such benefit would be includible in the gross income of the employee if provided directly by the employer (or would be so includible but for any provision of this chapter excluding such benefit from gross income).

**"SEC. 420B. FUNDED RESERVE ACCOUNT.**

''(a) GENERAL RULE.—For purposes of this subpart and section 401(h), the term 'funded reserve account' means an account within a health benefits account—

''(1) to which contributions paid or accrued to a defined benefit plan are allocated to provide a reserve for the payment of qualified section 401(h) medical benefits of employees and their spouses and dependents,

''(2) with respect to which the only contributions allocated are employer contributions, and

''(3) with respect to which—

''(A) the vesting requirements of subsection (c),

''(B) the portability requirements of subsection (d), and

''(C) the availability requirements of subsection (e),

are met.

''(b) LIMITATION ON ALLOCATION TO ACCOUNT.—

''(1) IN GENERAL.—No amount may be allocated to a funded reserve account (and taken into account under section 420A(c)(1)(B)) to the extent such addition results in the amount allocated to such account exceeding the account limit.

''(2) ACCOUNT LIMIT.—The account limit for any taxable year is an amount equal to 125 percent of the termination liability of the account as of the close of the last plan year ending with or within the taxable year.

''(3) TERMINATION LIABILITY.—For purposes of this section—

''(A) IN GENERAL.—The term 'termination liability' means the present value of the qualified section 401(h) medical benefits—

''(i) which are to be provided to employees (and their spouses and dependents), and

''(ii) any portion of which is to be provided through a funded reserve account.

''(B) DETERMINATIONS.—The termination liability under subparagraph (A) shall be determined—

''(i) on the basis of actuarial assumptions which are used in determining the full-funding limitation of the plan under section 412(c)(7),

''(ii) as if the benefits under the plan commenced at Social Security retirement age, and

''(iii) by not taking into account any portion of the maximum annual benefit under the plan for—

''(I) benefits (other than post-retirement long-term health care benefits) in excess of $1,500, or

''(II) post-retirement long-term health care benefits in excess of $1,500.

''(C) ADJUSTMENTS TO ACCOUNT.—The amount in the account shall be adjusted at such time and in such manner as the Secretary may prescribe to take into account income, gains, deductions, or losses which are properly allocable to amounts in the account.

''(D) ACTUARIAL ADJUSTMENT.—For purposes of determining termination liability, the benefits provided to any participant under the plan shall be actuarially adjusted to reflect any commencement of benefits before or after Social Security retirement age.

''(E) EMPLOYEE.—For purposes of this paragraph, the term 'employee' does not include a former employee.

''(F) COST-OF-LIVING ADJUSTMENT.—In the case of years beginning after 1995, the $1,500 amounts in subparagraph (B) shall be adjusted annually at the same time and in the same manner as under section 415(d).

''(c) VESTING REQUIREMENTS.—

''(1) IN GENERAL.—The requirements of this subsection are met if the requirements of either subparagraph (A) or (B) of section 411(a)(2) are met with respect to the accrued qualified section 401(h) medical benefits derived from amounts which are allocated to the funded reserve account.

''(2) UNIFORM RATE OF ACCRUAL OF BENEFITS.—

''(A) IN GENERAL.—Except as provided in this paragraph, a plan shall not be treated as meeting the requirements of this subsection unless the rate at which benefits accrue during a plan year is the same for all participants.

''(B) SPECIAL RULES FOR CERTAIN INDIVIDUALS AGE 55 AND OVER.—A plan shall not be treated as failing to meet the requirements of this subsection if the plan provides that an employee who as of the close of the plan year in which he attains age 55 has accrued less

than 30 percent of the maximum amount of benefits which may be accrued under the plan may accrue benefits during succeeding plan years at a greater rate than the rate for other employees (but not in excess of 125 percent of such other rate).

''(C) MINIMUM HOURS OF SERVICE.—For purposes of subparagraph (A), an employee shall not be treated as a participant for any plan year unless such individual completes more than 500 hours of service during such year.

''(3) CERTAIN RULES MADE APPLICABLE.—Except to the extent inconsistent with the provisions of this subpart, the rules of section 411 shall apply for purposes of this subsection.

''(d) PORTABILITY REQUIREMENTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the requirements of this subsection are met if, in accordance with procedures determined by the Secretary, the plan provides that—

''(A) except as provided in regulations, the plan shall transfer, within 120 days after an employee separates from service with the employer or after the termination of the plan, the present value of the nonforfeitable accrued

qualified section 401(h) medical benefits of the employee attributable to amounts which are allocated to the funded reserve account to—

''(i) a plan which is maintained by an employer of such employee and which maintains a health benefits account, or

''(ii) if the employer does not maintain a plan described in clause (i), an individual retirement account established for the benefit of such employee, and

''(B) the plan accepts transfers under subparagraph (A) from another plan or individual retirement account.

''(2) NO TRANSFERS AFTER EMPLOYEE IS DISABLED OR ATTAINS RETIREMENT AGE.—Except in the case of a termination of a plan, a plan shall not meet the requirements of this subsection if it permits the transfer of a benefit after—

''(A) an employee has attained Social Security retirement age, or

''(B) an employee has become disabled (within the meaning of section 72(m)(7)).

''(3) INCLUSION IN INCOME WHERE MORE THAN 1 ACCOUNT.—

''(A) IN GENERAL.—If—

''(i) an individual is a participant or beneficiary under 2 or more plans maintaining a funded reserve account or individual retirement account to which assets were transferred from such a plan, and

''(ii) such individual does not (within a reasonable period) consolidate the present value of the individual's nonforfeitable accrued benefit in all such plans and the assets so transferred to all such accounts into 1 such plan or into 1 such account,

then an amount equal to the sum of the present value of such benefits and the fair market value of such assets shall be treated as distributed in cash to such individual at the close of the plan year for the plan or account involved and such distribution shall be included in gross income.

''(B) SPECIAL RULES.—

''(i) EMPLOYEE MUST CONSOLIDATE INTO PLAN OF CURRENT EMPLOYER.—In the case of an employee who is employed by an employer maintaining a plan described in subparagraph (A)(i), a consolidation satisfies subparagraph (A) only if

such consolidation is into such a plan maintained by such employer.

''(ii) MORE THAN 1 CURRENT EMPLOYER.—If an individual is a participant in more than 1 plan described in subparagraph (A)(i) by reason of being currently employed by more than 1 employer, such plans shall be treated as 1 plan for purposes of subparagraph (A).

''(iii) EMPLOYEE WITH NO CURRENT EMPLOYER MAINTAINING PLAN.—In the case of an employee who is currently not employed by an employer maintaining a plan described in subparagraph (A)(i), a consolidation satisfies subparagraph (A) only if such consolidation is into—

''(I) a plan described in subparagraph (A)(i) maintained by his most recent employer maintaining such plan, or

''(II) an individual retirement account of the individual.

''(C) AMOUNT TRANSFERRED NOT INCLUDIBLE IN INCOME.—No amount shall be includible in gross income by reason of any transfer

which is part of a consolidation required under this paragraph.

''(e) RETIRED EMPLOYEES NOT COVERED BY HEALTH BENEFITS ACCOUNT MAY ELECT COVERAGE.—

''(1) IN GENERAL.—The requirements of this subsection are met if the plan provides that a former employee who—

''(A) is in pay status under the plan, but

''(B) is not eligible to receive all or any portion of qualified section 401(h) medical benefits provided for any period through the funded reserve account,

is entitled to elect such benefits for himself or his spouse and dependents. A plan shall not be treated as failing to meet the requirements of this subsection if an employee is required to pay a premium for such benefits as long as such premium does not exceed 102 percent of applicable premium for the period such benefits are provided.

''(2) APPLICABLE PREMIUM.—For purposes of paragraph (1), the applicable premium for any period shall be determined in the same manner as under section 4980B(f)(4).

**"SEC. 420C. DEFINITIONS; SPECIAL RULES.**

''(a) QUALIFIED SECTION 401(h) MEDICAL BENEFITS.—For purposes of this subpart, the term 'qualified section 401(h) medical benefits' means benefits—

''(1) which are—

''(A) benefits for sickness, accident, hospitalization, and medical expenses of former employees who are in pay status under the plan (and their spouse or dependents) after the former employee—

''(i) has attained Social Security retirement age, or

''(ii) is disabled (within the meaning of section 72(m)(7)), or

''(B) post-retirement long-term health care benefits, and

''(2) which are provided through 1 or more of the following:

''(A) insurance acquired by the plan, or

''(B) self-insurance by the employer or the plan.

''(b) POST-RETIREMENT LONG-TERM HEALTH CARE.—For purposes of this subpart—

''(1) IN GENERAL.—The term 'post-retirement long-term health care' means long-term health care benefits provided to a former employee (or the

spouse of the former employee) who is in pay status under the plan after the former employee—

''(A) has attained Social Security retirement age, or

''(B) is disabled (within the meaning of section 72(m)(7)).

''(2) SPOUSE OF DECEASED EMPLOYEE.—For purposes of paragraph (1), the spouse of a deceased employee shall be treated—

''(A) as a former employee, and

''(B) as satisfying the requirements of paragraph (1) if such spouse was receiving benefits immediately before the death of the employee.

''(3) LONG-TERM HEALTH CARE BENEFIT.—

''(A) IN GENERAL.—The term 'long-term health care benefit' means a benefit which consists of the providing by a qualified provider in a qualified facility of necessary diagnostic, preventive, therapeutic, rehabilitative, and personal care services, required by a chronically ill individual.

''(B) CERTAIN ITEMS NOT INCLUDED.—The term 'long-term health care benefits' does not include basic medicare supplement cov-

erage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

''(4) QUALIFIED FACILITY.—The term 'qualified facility' means—

''(A) a rehabilitative, hospice, or adult day care facility, including a hospital, retirement home, skilled nursing facility (within the meaning of section 1919(a) of the Social Security Act), or other similar facility determined by the plan administrator, or

''(B) a home where the chronically ill individual resides.

''(5) CHRONICALLY ILL INDIVIDUAL.—The term 'chronically ill individual' means an individual whose disability is such that the individual has been certified as requiring assistance with daily living (as defined by the plan administrator) for a period of at least 90 days.

''(6) QUALIFIED PROVIDER.—The term 'qualified provider' means a medical practitioner licensed

under State law, registered nurse, licensed vocational nurse, qualified therapist, or trained home health aide (or any organization employing such providers), but does not include a relative or other person who ordinarily resides in the home where the chronically ill individual resides.

''(c) HEALTH BENEFITS ACCOUNT.—For purposes of this subpart, the term 'health benefits account' means an account established and maintained under section 401(h).

''(d) SOCIAL SECURITY RETIREMENT AGE.—For purposes of this subpart, the term 'Social Security retirement age' has the meaning given such term by section 415(b)(8).''

(b) INDIVIDUAL RETIREMENT ACCOUNTS.—

(1) IN GENERAL.—Section 408 of such Code is amended by redesignating subsection (p) as subsection (q) and by inserting after subsection (o) the following new subsection:

''(p) SPECIAL RULES FOR FUNDED RESERVE ACCOUNTS.—

''(1) IN GENERAL.—A trust shall not be treated as an individual retirement account under subsection (a) unless the trust instrument provides that the trust will accept transfers of assets as provided in section 420B(d)(1).

''(2) ACCOUNTING.—The trustee of an individual retirement account shall maintain separate accounting for assets transferred to the account under section 420B(d)(1) (and any income allocable thereto).''

(2) PENALTY FOR EARLY DISTRIBUTIONS.—Section 72(t) of such Code (relating to 10-percent additional tax on early distributions) is amended by adding at the end the following new paragraph:

''(6) EARLY DISTRIBUTION OF MEDICAL BENEFITS.—If—

''(A) a taxpayer receives a distribution of amounts transferred to an individual retirement account under section 420B(d)(1) (or any income or gain allocable thereto), and

''(B) such distribution—

''(i) is made before the individual attains Social Security retirement age (within the meaning of section 415(b)(8)) or becomes disabled (within the meaning of subsection (m)(7)), or

''(ii) exceeds the amount of qualified section 401(h) medical expenses of the taxpayer, his spouse, or dependents for the taxable year,

then paragraph (1) shall apply to such distribution or such excess, except that '50 percent' shall be substituted for '10 percent'. Paragraph (2) shall not apply to a distribution to which this paragraph applies.''

(c) EXCISE TAX ON ALLOCATED ASSETS NOT USED TO PROVIDE RETIREE HEALTH BENEFITS.—Section 4980 of such Code (relating to tax on reversion of qualified plan assets to employers) is amended by adding at the end the following new subsection:

''(e) ASSETS ALLOCATED TO RETIREE HEALTH BENEFITS ACCOUNTS.—In the case of a plan which establishes a health benefits account described in section 401(h), if—

''(1) amounts are allocated to a funded reserve account under section 420B, and

''(2) any amount in such account is paid or distributed other than to pay for qualified section 401(h) medical benefits (as defined in section 420C(a)) provided through such account,

the amount so paid or distributed shall be treated as an employer reversion for purposes of this section, except that subsection (a) shall be applied by substituting '100 percent' for '25 percent'.''

(d) CONFORMING AMENDMENTS.—

(1) Section 419(e) of such Code (defining welfare benefit fund) is amended by adding at the end the following new paragraph:

''(5) HEALTH BENEFITS ACCOUNTS.—The term 'welfare benefits fund' does not include any health benefits account established under section 401(h).''

(2) The table of subparts for part I of subchapter D of chapter 1 of such Code is amended by adding at the end the following new item:

''Subpart F. Treatment of health benefit accounts.''

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions after December 31, 1992.

(2) INDIVIDUAL RETIREMENT ACCOUNTS.—The amendments made by subsection (b) shall apply to accounts established after December 31, 1992.

## Subtitle C—Reverse Mortgage Insurance for Older Americans

**SEC. 221. MAXIMUM AMOUNT INSURED.**

Section 255(g) of the National Housing Act (12 U.S.C. 1715z–20(g)) is amended by striking the third sentence and inserting the following new sentence: ''In no case may the benefits of insurance under this section exceed the greater of 95 percent of the median 1-family

house price in the United States or 95 percent of the median 1-family house price in the area, as determined by the Secretary.''

# Subtitle D—Income Tax Credits

## SEC. 231. REFUNDABLE CREDIT FOR CUSTODIAL CARE OF CERTAIN DEPENDENTS IN TAXPAYER'S HOME.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 37 and by inserting after section 34 the following new section:

### ''SEC. 35. CREDIT FOR TAXPAYERS WITH CERTAIN PERSONS REQUIRING CUSTODIAL CARE IN THEIR HOUSEHOLDS.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual who maintains a household which includes as a member one or more qualified persons, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to $2,000 for each such person.

''(b) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED PERSON.—The term 'qualified person' means any individual—

''(A) who is a parent, grandparent, dependent (as defined in section 152), or spouse of the taxpayer,

''(B) who has been certified by a physician as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in paragraph (2)), or

''(ii) having a similar level of disability due to cognitive impairment, and

''(C) who has as his principal place of abode for more than half of the taxable year the home of the taxpayer.

''(2) ACTIVITIES OF DAILY LIVING.—For purposes of paragraph (1), each of the following is an activity of daily living:

''(A) BATHING.—The overall complex behavior of getting water and cleansing the whole body, including turning on the water for a bath, shower, or sponge bath, getting to, in, and out of a tub or shower, and washing and drying oneself.

''(B) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

''(C) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes.

''(D) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

''(E) EATING.—The process of getting food from a plate or its equivalent into the mouth.

''(3) PHYSICIAN.—The term 'physician' means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the jurisdiction in which he makes the determination under paragraph (1).

''(d) SPECIAL RULES.—For purposes of this section—

''(1) MAINTAINING A HOUSEHOLD.—An individual shall be treated as maintaining a household for any period if over half the cost of maintaining the household for such period is furnished by such indi-

vidual (or, if such individual is married during such period, by such individual and his spouse).

''(2) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married at the close of the taxable year, the credit under subsection (a) shall be allowed only if the taxpayer and his spouse file a joint return for the taxable year.

''(3) MARITAL STATUS.—An individual legally separated from his spouse under a decree of divorce or separate maintenance shall not be considered as married.

''(4) CERTAIN MARRIED INDIVIDUALS LIVING APART.—If—

''(A) an individual who is married and who files a separate return—

''(i) maintains a household which includes as a member one or more qualified persons, and

''(ii) furnishes over half of the cost of maintaining such household during such taxable year, and

''(B) during the last 6 months of such taxable year such individual's spouse is not a member of such household,

such individual shall not be considered as married.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''

(b) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the item relating to section 35 and inserting the following:

''Sec. 35. Credit for taxpayers with certain persons requiring custodial care in their households.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

**SEC. 232. CREDIT FOR EXPENSES FOR LONG-TERM CARE SERVICES PROVIDED TO CERTAIN INDEPENDENT PERSONS REQUIRING SUCH CARE.**

(a) GENERAL RULE.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 35 the following new section:

**''SEC. 36. CREDIT FOR EXPENSES FOR LONG-TERM CARE SERVICES PROVIDED TO CERTAIN INDEPENDENT PERSONS REQUIRING SUCH CARE.**

''(a) GENERAL RULE.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to

25 percent of the qualified long-term care expenses paid during such taxable year.

''(b) MAXIMUM CREDIT.—

''(1) IN GENERAL.—The credit allowed by subsection (a) for any taxable year shall not exceed $2,000 with respect to each independent qualified person.

''(2) PHASEOUT OF CREDIT FOR TAXPAYERS WITH INCOMES EXCEEDING 150 PERCENT OF THE POVERTY LEVEL.—If the adjusted gross income of the taxpayer for the taxable year exceeds the base amount, the $2,000 amount in paragraph (1) shall be reduced (but not below zero) by an amount which bears the same ratio to $2,000 as—

''(A) the excess of the taxpayer's adjusted gross income for the taxable year over the base amount, bears to

''(B) $10,000.

For purposes of the preceding sentence, the base amount is 150 percent of the poverty level applicable to the taxpayer.

''(c) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED LONG-TERM CARE EXPENSES.—

''(A) IN GENERAL.—The term 'qualified long-term care expenses' means the amount paid by the taxpayer during the taxable year for 1 or more medically necessary, diagnostic services, preventive services, therapeutic services, rehabilitation services, maintenance services, or personal care services which are required by an independent qualified person and which are provided in the household referred to in paragraph (2)(C).

''(B) COVERAGE SPECIFICALLY EXCLUDED.—Such term does not include any combination of the following kinds of coverage:

''(i) Basic Medicare supplement coverage.

''(ii) Basic hospital-based acute care expense coverage.

''(iii) Basic medical-surgical expense coverage.

''(iv) Hospital confinement indemnity coverage.

''(v) Major medical expense coverage.

''(vi) Disability income protection coverage.

''(vii) Accident only coverage.

''(viii) Specified disease coverage.

''(ix) Specified accident coverage.

''(x) Limited benefit health coverage.

''(2) INDEPENDENT QUALIFIED PERSON.—The term 'independent qualified person' means any individual—

''(A) who is a parent, grandparent, or dependent (as defined in section 152) of the taxpayer,

''(B) who has been certified by a physician as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in section 35(b)(2)), or

''(ii) having a similar level of disability due to cognitive impairment, and

''(C) who maintains a household which is his principal place of abode for more than half of the taxable year of the taxpayer.

Such term shall not include any qualified person as defined in section 35(b).''

(b) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1

of such Code is amended by adding at the end the following:

''Sec. 36. Credit for expenses for long-term care services provided to certain independent persons requiring such care.
''Sec. 37. Overpayments of tax.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

# Subtitle E—Treatment of Accelerated Death Benefits

### SEC. 241. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 of the Internal Revenue Code of 1986 (relating to certain death benefits) is amended by adding at the end thereof the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount paid to an individual under a life insurance contract on the life of an insured who is a terminally ill individual or who is permanently confined to a nursing home shall be treated as an amount paid by reason of the death of such insured.

''(2) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who has been certified

by a physician, licensed under State law, as having an illness or physical condition which can reasonably be expected to result in death in 12 months or less.

''(3) PERMANENTLY CONFINED TO A NURSING HOME.—For purposes of this subsection, an individual has been permanently confined to a nursing home if the individual is presently confined to a nursing home and has been certified by a physician, licensed under State law, as having an illness or physical condition which can reasonably be expected to result in the individual remaining in a nursing home for the rest of his life.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1992.

**SEC. 242. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.**

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 of the Internal Revenue Code of 1986 (relating to other definitions and special rules) is amended by adding at the end thereof the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider or addendum on, or other provision of, a life insurance contract which provides for payments to an individual on the life of an insured upon such insured becoming a terminally ill individual (as defined in section 101(g)(2)) or being permanently confined to a nursing home (as defined in section 101(g)(3)).''

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—

(1) RIDER TREATED AS QUALIFIED ADDITIONAL BENEFIT.—Paragraph (5)(A) of section 7702(f) of such Code is amended by striking ''or'' at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

''(v) any qualified accelerated death benefit rider (as defined in section 818(g)(2)) or any qualified long-term care insurance rider which reduces the death benefit, or''.

(2) TRANSITIONAL RULE.—For purposes of applying section 7702 or 7702A of the Internal Revenue Code of 1986 to any contract (or determining whether either such section applies to such contract), the issuance of a rider or addendum on, or other provision of, a life insurance contract permitting the acceleration of death benefits (as described in section 101(g) of such Code) or for qualified long-term care insurance (as defined in section 849(b) of such Code) shall not be treated as a modification or material change of such contract.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning before, on, or after December 31, 1992.

# Subtitle F—Federal National Long-Term Care Reinsurance Corporation

### SEC. 251. AUTHORIZATION FOR ESTABLISHMENT OF CORPORATION.

The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') is authorized to provide, in accordance with this subtitle, for the incorporation of a corporation to be known as the Federal National Long-Term Care Reinsurance Corporation (in this subtitle referred to as the ''Corporation''), which shall not be an agency or establishment of the United States Government.

### SEC. 252. BOARD OF DIRECTORS AND OFFICERS.

(a) BOARD OF DIRECTORS.—The Corporation shall have a Board of Directors (in this subtitle referred to as the ''Board'') consisting of 9 members, of which—

(1) 3 shall be appointed by the President of the United States, of which one shall be representative of entities providing long-term care, one shall be a representative from an insurer, and one shall be a representative of consumers of long-term care; and

(2) 6 shall be elected annually by the stockholders of the Corporation entitled to vote for such members.

Within the limitations of law and regulation, the Board shall determine the general policies which shall govern the operations of the Corporation, and shall have power to adopt, amend, and repeal bylaws governing the performance of the powers and duties granted to or imposed upon it by law.

(b) INITIAL BOARD.—Notwithstanding subsection (a), the members described in subsection (a)(1) shall serve as incorporators and are authorized to assist the Secretary in taking whatever actions are necessary to incorporate the Corporation.

(c) TERMS OF OFFICE.—The terms of office of each member of the Board shall be one year, expiring on the date of the annual meeting of the stockholders of the Corporation; except that (1) in the case of a vacancy occurring prior to the expiration of the term of a member, the vacancy shall be filled by the President (for members described in subsection (a)(1)) or by the remaining members of the Board (for other members) for the remainder of such term, and (2) any member may be removed by the President for good cause. Any vacancy in the Board shall not affect its power.

(d) CHAIRMAN.—The President shall designate one of the members described in subsection (a)(1) as the initial Chairman of the Board. Thereafter, the members of the

Boards shall annually elect one of their number as Chairman.

(e) TREATMENT OF MEMBERS.—

(1) The members of the Board shall not by reason of such membership, be deemed to be employees of the United States Government. Except as provided in paragraph (2), each member of the Board shall be entitled to receive the daily equivalent of the maximum annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including travel time) during which he is engaged in the actual performance of duties vested in the Corporation.

(2) Members of the Board who are full-time officers or employees of the United States shall receive no additional pay by reason of their service on the Board.

(f) OFFICERS.—The Corporation shall have a President and such other executive officers and employees as may be appointed by the Board at rates of compensation fixed by the Board, without regard to any provisions of title 5, United States Code. No such executive officer may receive any salary or other compensation from any source other than the Corporation during the period of his employment by the Corporation.

**SEC. 253. PURPOSE AND AUTHORITY OF CORPORATION.**

(a) PURPOSE.—The Corporation shall confine its activities to providing for the reinsurance of insurance companies for extraordinary loss in the issuance or payment of benefits for qualified long-term care insurance (as defined in section 848(b) of the Internal Revenue Code of 1986). Except as may be provided by the Secretary in regulations, the Corporation may not refuse to provide for such reinsurance for any insurance meeting the requirements of such section (other than paragraph (4)(C)(iii) thereof).

(b) PREMIUMS.—The Corporation shall impose for such reinsurance reasonable premiums which—

(1) are related to actuarial estimates of the type and amount of financial risk assumed by the Corporation, and

(2) in the aggregate (in conjunction with other income which the Corporation may have) provide for all the expenses of the Corporation.

(c) NO POLITICAL CONTRIBUTIONS.—The Corporation shall not contribute or otherwise support any political party or candidate for elective public office.

(d) GENERAL POWERS.—Except as otherwise specifically provided in this subtitle, the Corporation and Board shall have the powers of a corporation and board of directors in the State in which incorporated.

**SEC. 254. CAPITALIZATION.**

(a) COMMON STOCK.—The Corporation shall have common stock, with such par value as the Board establishes, which shall be vested with all voting rights, each share being entitled to one vote with rights of cumulative voting at all elections of directors. The free transferability of the common stock at all times to any person, firm, corporation, or other entity shall not be restricted, except that, as to the Corporation, it shall be transferable only on the books of the Corporation. The Corporation shall only issue such common stock with the approval of the Secretary.

(b) DEBT.—

(1) For purposes of carrying out this subtitle, the Corporation may, with the approval of the Secretary and consistent with section 258, issue obligations having such maturities and bearing such rate or rates and having such conditions (including subordination to other such obligations) as the Board determines to be appropriate.

(2) The full faith and credit of the United States is not pledged to the obligations and debts of the Corporation. The Corporation shall insert appropriate language in all of its obligations issued under this subsection clearly indicating that such obligations, together with the interest thereon, are not

guaranteed by the United States and do not constitute debt or obligation of the United States or of any agency or instrumentality thereof. The Corporation may purchase in the open market any of its obligations outstanding under this subsection at any time and at any price.

(3) All obligations, participations, or other instruments issued by the Corporation shall be lawful investments, and may be accepted as security for all fiduciary, trust, and public funds, the investment or deposit of which shall be under the authority and control of the United States or any officer or officers thereof.

**SEC. 255. EXEMPTION FROM STATE REGULATION AND TAXATION.**

(a) TAXATION.—The Corporation, including its capital, reserves, surplus, security holdings, and income, shall be exempt from all taxation now or hereafter imposed by any State, district, Commonwealth, county, municipality, or local taxing authority, except that any real property of the Corporation shall be subject to such taxation to the same extent according to its value as other real property is taxed.

(b) INSURANCE REGULATION.—Except to the extent specified by the Secretary in regulations, the Corporation

shall not be subject to any regulation under the insurance laws of any State, district, or Commonwealth.

**SEC. 256. AUDIT AND ANNUAL REPORT.**

(a) AUDIT.—The Board shall provide for an annual audit of the operations of the Corporation. Such audit shall be conducted by a certified public accountant in accordance with generally accepted auditing principles (as recognized by the Comptroller General).

(b) ANNUAL REPORT.—The Board shall report annually to the President and the Congress on the activities of the Corporation. Such report shall include a presentation of the financial status of the Corporation, as certified under the audit described in subsection (a).

**SEC. 257. PROTECTION OF NAME.**

No individual association, partnership, or corporation, except the Corporation, shall hereafter use the word ''Federal National Long-Term Care Reinsurance Corporation'', or any combination of such words, as the name or a part thereof under which he or it shall do business. Violations of the foregoing sentence may be enjoined by any court of general jurisdiction at the suit of the Corporation. In any such suit, the Corporation may recover any actual damages flowing from such violations, and, in addition, shall be entitled to punitive damages (regardless of the existence or nonexistence of actual damages) of not ex-

ceeding $10,000 for each day during which such violation is committed or repealed.

**SEC. 258. TERMINATION.**

The Corporation shall terminate its activities not later than 10 years after the date of the enactment of this Act.

# TITLE III—MALPRACTICE LIABILITY REFORM

**SEC. 301. DEFINITIONS.**

In this title, the following definitions shall apply:

(1) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for medical expenses, lost wages or other income, lost employment, burial expenses, and other pecuniary losses.

(2) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought against a health care provider (regardless of the theory of liability on which the action is based) in which a plaintiff alleges an injury caused by the provision of (or the failure to provide) health care services, except that such term does not include—

(A) any action in which a plaintiff alleges an intentional tort; or

(B) any action in which the plaintiff's sole allegation is an allegation of an injury arising from the use of a medical product.

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual or entity that is engaged in the delivery of health care services and is required under Federal or State law to be licensed, certified, or accredited in order to deliver such services.

(4) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a health care liability action.

(5) NON-ECONOMIC DAMAGES.—The term ''non-economic damages'' means any damages paid to compensate an individual for subjective, non-monetary losses, including pain, suffering, inconvenience, mental suffering, emotional distress, loss of society and companionship, loss of consortium, injury to reputation, and humiliation, but does not include punitive damages.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands,

Guam, American Samoa, and the Northern Mariana Islands.

**SEC. 302. MALPRACTICE LIABILITY REFORM REQUIREMENTS DESCRIBED.**

(a) IN GENERAL.—Subject to section 303, a State meets the requirements of this section if it has enacted laws, rules, or regulations relating to the treatment of health care liability actions that meet the requirements of subsections (b) through (h), relating to alternative dispute resolution mechanisms that meet the requirements of subsection (i), and relating to quality assurance reform that meet the requirements of subsection (j).

(b) LIABILITY SEVERAL AND NOT JOINT FOR NON-ECONOMIC DAMAGES.—

(1) IN GENERAL.—With respect to non-economic damages, the liability of each defendant in a health care liability action shall be several only and shall not be joint. Each defendant shall be liable only for the amount of non-economic losses incurred by the plaintiff that is in direct proportion to the defendant's percentage of responsibility for the injury suffered by the plaintiff (as determined by the trier of fact pursuant to paragraph (2)).

(2) DETERMINATION OF PERCENTAGE OF RESPONSIBILITY.—The trier of fact shall determine the

extent of each defendant's responsibility for the non-economic injury suffered by the plaintiff, and shall assign a percentage of responsibility for such injury to each defendant.

(c) LIMITATION ON NON-ECONOMIC DAMAGES.—

(1) IN GENERAL.—The total amount of non-economic damages that may be awarded to an individual and the family members of such individual for losses resulting from an injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of health care providers against whom the action is brought or the number of actions brought with respect to the injury.

(2) ADJUSTMENT FOR INFLATION.—The amount referred to in paragraph (1) shall be increased every 3rd year (beginning with the 3rd year that begins after the date of the enactment of this Act) in the same manner as amounts are increased under section 215(i) of the Social Security Act for base quarters or cost-of-living computation quarters in such a year.

(d) MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.—

(1) IN GENERAL.—The total amount of damages received by an individual under a health care liability action shall be reduced (in accordance with paragraph (2)) by any other payment that has been or will be made to the individual to compensate the individual for the injury that was the subject of the health care liability action, including payment under—

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) private disability insurance programs;

(D) employer wage continuation programs; and

(E) any other source of payment intended to compensate such individual for such injury.

(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual shall be reduced under paragraph (1) shall be the total amount of any payments (other than such award) that have been made or that will be made to the individual to compensate the individual for the injury that was the subject of the action.

(f) TREATMENT OF PAYMENTS FOR FUTURE ECONOMIC LOSSES.—

(1) PROHIBITING SINGLE LUMP-SUM PAYMENT.—No health care provider shall be required to make a single, lump-sum payment for damages for any economic losses to be incurred after the date on which judgment is entered in a health care liability action, but shall be permitted to make periodic payments of such damages on the basis of projections of the amount of costs expected to be incurred by the plaintiff at appropriate intervals (as determined by the trier of fact).

(2) USE OF ANNUITIES OR TRUSTS.—The court may require a health care provider to purchase an annuity or fund a reversionary trust to make periodic payments under paragraph (1) if the court finds a reasonable basis for concluding that the health care provider may be unable to or will not otherwise make the periodic payments.

(3) REQUIREMENT OF PERIODIC PAYMENT AS FINAL ORDER.—The judgment of the court awarding periodic payments may not be reopened at any time to contest, amend, or modify the schedule or amount of the payments in the absence of fraud or any other

basis under which a party may obtain relief from a final judgment.

(4) LUMP-SUM PAYMENT UNDER SETTLEMENT NOT PRECLUDED.—Nothing in this subsection shall be construed to preclude the parties to a health care liability action from entering into a settlement providing for a single, lump-sum payment for damages described in paragraph (1).

(g) LIMITATION ON ATTORNEY'S FEES.—The amount of attorney's fees that may be collected by the attorney for any party to a health care liability action for services relating to the action may not exceed—

(1) 33 percent of the first $50,000 awarded to the party;

(2) 20 percent of the next $100,000 awarded to the party;

(3) 15 percent of the next $100,000 awarded to the party; and

(4) 10 percent of any amount in excess of $250,000 awarded to the party.

(h) SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.—

(1) IMPOSITION OF HIGHER STANDARD OF PROOF.—In the case of a health care liability action relating to services provided during labor or the de-

livery of a baby, if the plaintiff was not previously treated for the pregnancy by the defendant health care provider a court may not find that the defendant committed malpractice and may not assess damages against the defendant unless the malpractice is proven by clear and convincing evidence.

(2) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of paragraph (1), a health care provider shall be considered to have previously treated an individual for a pregnancy if the provider is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another provider.

(i) ESTABLISHMENT OF ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.—

(1) IN GENERAL.—Each State shall have in effect at least one mediation or pretrial screening panel that meets requirements specified in regulations issued by the Secretary, or shall have in effect another alternative dispute resolution mechanism which the Secretary, in consultation with the Attorney General, finds to be equally effective in deterring the filing of frivolous health care liability actions and

providing fair and expeditious compensation for meritorious health care liability claims.

(2) PROMULGATION OF REGULATIONS.—Subject to paragraph (3), the Secretary, in consultation with the Administrative Conference of the United States and the Attorney General, shall promulgate regulations that specify the Secretary's criteria for mediation and pretrial screening panels and for evaluating the effectiveness of other alternative dispute resolution mechanisms under paragraph (1).

(3) TOLLING OF STATUTE OF LIMITATIONS DURING ALTERNATIVE PROCEDURES.—Any regulations promulgated by the Secretary pursuant to paragraph (2) shall include a requirement that a State may not include any time occurring after a claim is filed with a mediation or pretrial screening panel or under any other alternative dispute resolution mechanism under paragraph (1) for purposes of determining the applicability of any statute of limitations to a health care liability action arising from the injury that is the subject of the claim.

(j) QUALITY ASSURANCE REFORM.—

(1) IMPROVING THE PERFORMANCE OF STATE MEDICAL BOARDS.—(A) The State, through the appropriate health authority, shall collect, analyze and

supply the Secretary with information and data, as specified in regulations to be promulgated by the Secretary, on staffing, revenue, disciplinary actions, expenditures, case-loads of the State Medical Board, and use of continuing medical education programs in order to demonstrate that the State medical boards meet performance criteria established by the Secretary in regulations.

(B) The State, through the appropriate health authority, shall impose a requirement on the State Medical Board to require a physician disciplined by the State Medical Board to take a certain number of continuing education courses as the board requires, with educational outcome measures required, in the subject areas in which the board determines that the physician's knowledge is deficient.

(2) ALTERNATIVE PROGRAMS.—The Secretary shall deem a State in compliance with the requirements of this section if (instead of complying with the requirements of paragraph (1)) the State has in effect a program to reduce the incidence of physician negligence which the Secretary finds to be at least as effective in reducing the incidence of negligence as compliance with the requirements of paragraph

(1), in accordance with criteria established by the Secretary that may include—

(A) requirements for risk management systems to be carried out by institutions providing health care in the State;

(B) quality assurance systems, administered by the State or professional bodies, which review the quality of care rendered by the physicians of the State; or

(3) State programs for the promulgation of standards of care in areas of medical practice in which the risk of negligence is greatest.

**SEC. 303. WAIVER OF REQUIREMENTS FOR GOOD CAUSE OR FOR CARRYING OUT DEMONSTRATION PROJECTS.**

The Secretary may waive any of the requirements of subsections (b) through (j) of section 302 for good cause or to the extent necessary to enable a State to carry out an experimental, demonstration, or pilot project if, in the judgment of the Secretary, the project is likely to promote the objectives of this title.

**SEC. 304. CERTIFICATION OF STATE COMPLIANCE.**

(a) NOTIFICATION.—

(1) IN GENERAL.—Not later than 6 months before the beginning of each year (beginning with the

first year that begins after the expiration of the 3-year period beginning on the date of the enactment of this Act), each State shall submit a notification to the Secretary, with a certification by the Chief Executive Officer of the State that, on the date the notification is submitted, the State has enacted, adopted, or otherwise has in effect laws, rules, or regulations that meet the requirements of section 302.

(2) CONTENTS OF NOTIFICATION.—The notification shall be accompanied by documentation to support the certification required by this subsection, including copies of relevant State statutes, rules, procedures, regulations, judicial decisions, State constitutional provisions, and opinions of the State Attorney General, and shall contain such other information, be in such form, and be submitted in such manner, as the Secretary may require.

(b) REVIEW OF NOTIFICATION.—

(1) IN GENERAL.—Within 90 days after receiving a notification under subsection (a), the Secretary shall review the notification and determine whether the notification demonstrates that the State has enacted, adopted, or otherwise has in effect laws, rules,

or regulations that meet the requirements of section 302.

(2) APPROVAL OF NOTIFICATION.—If the Secretary determines that the notification makes such demonstration, the Secretary shall approve the notification.

(3) NOTICE OF DISAPPROVAL.—If, after reviewing a State's notification under subsection (a), the Secretary determines that the notification does not make the demonstration required, the Secretary shall, not later than 15 days after making such determination, provide the State with a written notice specifying such determination and containing recommendations for revisions which would cause the notification of the State to be approved.

(4) REVIEW OF REVISED NOTIFICATIONS.—Not later than 30 days after receiving a revised notification, the Secretary shall review the revised notification and determine whether the notification demonstrates that the State has enacted, adopted, or otherwise has in effect laws, rules, or regulations that meet the requirements of section 302. If the Secretary determines that the revised notification makes such a demonstration, the Secretary shall approve the revised notification.

(c) NON-COMPLIANCE.—

(1) FAILURE TO SUBMIT NOTIFICATION.—If a State fails to submit to the Secretary a notification or revised notification pursuant to this section, the Secretary shall, not later than 15 days after the period provided for submitting notification under this section, send the State written notice of determination of non-compliance.

(2) FAILURE TO MEET REQUIREMENTS.—If the Secretary determines that a revised notification submitted under subsection (b) does not demonstrate that the State has enacted, adopted, or otherwise has in effect laws, rules, or regulations that meet the requirements of section 302, and disapproves the State's revised notification, the Secretary shall, not later than 15 days after making such determination, provide the State with written notice of non-compliance, including the determination of the Secretary and the reasons therefore.

(3) FAILURE TO MEET REQUIREMENTS AFTER INITIAL APPROVAL.—If, during any time period after a notification is approved under this section, the Secretary determines that the State does not have currently in effect or has ceased enforcing the laws, rules, or regulations upon which the notification was

approved, the Secretary shall, not later than thirty days of making such determination provide the State with written notice of such determination and withdraw the approval of the notification. Such notice shall specify the determination of the Secretary and the reasons therefore.

(d) CONSULTATION WITH ATTORNEY GENERAL.—In making determinations of compliance or non-compliance pursuant to this section, the Secretary shall consult with the Attorney General.

**SEC. 305. INCENTIVES THROUGH MEDICARE AND MEDICAID.**

(a) MEDICARE INCENTIVES.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) PAYMENT INCENTIVES TO ENCOURAGE MEDICAL MALPRACTICE LIABILITY REFORM.—

''(1) REDUCTION IN PAYMENTS FOR HOSPITALS LOCATED IN CERTAIN STATES.—Notwithstanding any other provision of this title, the Secretary shall reduce each payment amount otherwise determined under this section by 1 percent for discharges during a cost reporting period with respect to hospitals that are not located in a State which the Secretary cer-

tifies (pursuant to section 304 of the Health Care Choice and Access Improvement Act of 1992) meets the requirements of section 302 of the Health Care Choice and Access Improvement Act of 1992 for the cost reporting period.

''(2) ADDITIONAL PAYMENT FOR HOSPITALS LOCATED IN STATES ENACTING REFORMS.—With respect to hospitals that are not subject to a reduction in payment under paragraph (1), the Secretary shall make an additional payment for discharges during a cost reporting period equal to the product of—

''(A) an amount equal to the total of all amounts that were not paid to hospitals during the cost reporting period as a result of the reductions made under such paragraph; and

''(B) a percentage equal to the percentage of all payments under this section during the year to all hospitals that are not subject to the reduction described in such paragraph that is attributable to payments to that hospital.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to discharges for cost reporting periods beginning on or after the first day of the first fiscal year that begins

after the expiration of the 3-year period beginning on the date of the enactment of this Act.

(b) MEDICAID INCENTIVES.—

(1) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (r) the following new subsection:

''(s)(1)(A) In order for a State to receive payments under paragraph (7) of subsection (a) for quarters in a year without being subject to the reduction described in subparagraph (B), the Secretary must certify (pursuant to section 304 of the Health Care Choice and Access Improvement Act of 1992) that the State meets the requirements of section 302 of the Health Care Choice and Access Improvement Act of 1992 for the year.

''(B) If a State is not certified for a year by the Secretary under subparagraph (A), the per centum specified in paragraph (7) of subsection (a) with respect to the State shall be reduced by 2 percentage points for quarters during the year.

''(2) In the case of a State that is not subject to the reduction described in paragraph (1)(B) for quarters during a year, the Secretary shall make an additional payment to the State equal to the product of—

''(A) an amount equal to the total of all amounts that were not paid to States during the year as a result of the reductions made under such paragraph; and

''(B) a percentage equal to the percentage of all payments under this section during the year to all States that are not subject to the reduction described in such paragraph that is attributable to payments to that State.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to calendar quarters beginning on or after the first January 1 that begins after the expiration of the 3-year period beginning on the date of the enactment of this Act.

**SEC. 306. APPLICABILITY OF CERTAIN PROVISIONS TO FEDERAL TORT CLAIMS ACT.**

(a) IN GENERAL.—Chapter 171 of title 28, United States Code, is amended by adding at the end the following new section:

**''§ 2681. Special rules for health care liability actions**

''(a) Notwithstanding any other provision of this chapter, any action brought against the United States under this chapter that is a health care liability action shall be subject to the following:

''(1)(A) With respect to non-economic damages, the liability of the United States shall be several only and shall not be joint. The United States shall be liable only for the amount of non-economic losses incurred by the plaintiff that is in direct proportion to the United States' percentage of responsibility for the injury suffered by the plaintiff (as determined by the court pursuant to subparagraph (B)).

''(B) The court shall determine the extent of each defendant's responsibility for the non-economic injury suffered by the plaintiff, and shall assign a percentage of responsibility for such injury to each defendant.

''(2)(A) The total amount of non-economic damages that may be awarded to an individual and the family members of such individual for losses resulting from an injury which is the subject of the action may not exceed $250,000, regardless of the number of defendants against whom the action is brought or the number of actions brought with respect to the injury.

''(B) The amount referred to in subparagraph (A) shall be increased every 3rd year (beginning with the 3rd year that begins after the date of the enactment of this Act) in the same manner as

amounts are increased under section 215(i) of the Social Security Act for base quarters or cost-of-living computation quarters in such a year.

''(3)(A) The total amount of damages received by an individual shall be reduced (in accordance with subparagraph (B)) by any other payment that has been or will be made to the individual to compensate the individual for the injury that was the subject of the action, including payment under—

''(i) Federal or State disability or sickness programs;

''(ii) Federal, State, or private health insurance programs;

''(iii) private disability insurance programs;

''(iv) employer wage continuation programs; and

''(v) any other source of payment intended to compensate such individual for such injury.

''(B) The amount by which an award of damages to an individual shall be reduced under subparagraph (A) shall be the total amount of any payments (other than such award) that have been made or that will be made to the individual to compensate the individual for the injury that was the subject of the action.

''(4)(A) The United States may not be required to make a single, lump-sum payment for damages for any economic losses to be incurred after the date on which judgment is entered, but shall be permitted to make periodic payments of such damages on the basis of projections of the amount of costs expected to be incurred by the plaintiff at appropriate intervals (as determined by the court).

''(B) The United States may at its discretion purchase an annuity or fund a reversionary trust to make periodic payments under subparagraph (A).

''(C) The judgment of the court awarding periodic payments may not be reopened at any time to contest, amend, or modify the schedule or amount of the payments in the absence of fraud or any other basis under which a party may obtain relief from a final judgment.

''(D) Nothing in this paragraph shall be construed to preclude the parties to an action from entering into a settlement providing for a single, lump-sum payment for damages described in subparagraph (A).

''(b) In this section, the following definitions shall apply:

''(1) The term 'economic damages' means damages paid to compensate an individual for medical expenses, lost wages or other income, lost employment, burial expenses, and other pecuniary losses.

''(2) The term 'health care liability action' means a civil action brought against the United States (regardless of the theory of liability on which the action is based) in which a plaintiff alleges an injury caused by the provision of (or the failure to provide) health care services, except that such term does not include—

''(A) any action in which a plaintiff alleges an intentional tort; or

''(B) any action in which the plaintiff's sole allegation is an allegation of an injury arising from the use of a medical product.

''(3) The term 'injury' means any illness, disease, or other harm that is the subject of a health care liability action.

''(4) The term 'non-economic damages' means any damages paid to compensate an individual for subjective, non-monetary losses, including pain, suffering, inconvenience, mental suffering, emotional distress, loss of society and companionship, loss of

consortium, injury to reputation, and humiliation, but does not include punitive damages.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 171 of title 28, United States Code, is amended by adding at the end the following new item:

''2681. Special rules for health care liability actions.''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to actions brought against the United States on or after the date of the enactment of this Act.

**SEC. 307. RULES OF CONSTRUCTION.**

Nothing in this title may be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any law or by the United States;

(2) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation;

(3) affect the right of any court to transfer venue, to apply the law of a foreign nation, or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum;

(4) create or vest jurisdiction in the district courts of the United States over any health care li-

ability action subject to this Act (which is not otherwise properly in Federal district court); or

(5) prevent any State from enacting, adopting, or otherwise having in effect more comprehensive or additional health care liability reforms than those set forth in this Act.

# TITLE IV—WORKING AMERICANS ACCESS TO HEALTH CARE

## Subtitle A—Increase in Small Employer Access to Affordable Health Insurance

### SEC. 401. ESTABLISHMENT AND ENFORCEMENT OF STANDARDS FOR SMALL EMPLOYER HEALTH INSURANCE PLANS.

(a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The Secretary of Health and Human Services shall request the National Association of Insurance Commissioners to develop, within 1 year after the date of the enactment of this Act, model regulations that specify standards with respect to each of the following:

(A) The requirement, under section 403(a), that small employer carriers offer MedEquity plans.

(B) The basic benefits to be included in MedEquity plans under section 403(b).

(C) The requirements of guaranteed issue of MedEquity plans under section 403(c).

(D) The requirements of sections 404 and 405(b).

(E) The requirements of subsections (a) and (c) of section 405.

If the NAIC develops such regulations specifying such standards within such period, the Secretary shall review such standards to determine if they meet such requirements. Such review shall be completed within 6 months after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this section.

(2) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not meet the requirements described in paragraph (1), the Secretary shall inform the NAIC of the specific deficiencies and request the NAIC to develop such model regulations in conformity with paragraph (1).

(3) EFFECTIVE DATE.—The standards provided under this subsection—

(A) shall apply to small employer health benefit plans offered in a State on or after the date the standards are implemented in the State under subsection (b)(1), and

(B) with respect to the requirements referred to in paragraph (1)(D), shall apply to small employer health benefit plans renewed on or after 3 years after the date such standards are implemented in the State under subsection (b)(1).

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF ALL STANDARDS TO NEW PLANS.—

(A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on the implementation and enforcement of the standards established under subsection (a) with respect to small employer health benefit plans offered not later than such deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date standards are established under subsection (a).

(ii) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for carriers and health benefit plans offered to small employers to meet the standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1993 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1993. For purposes of the previous sentence, in the

case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) APPLICATION OF CONSUMER PROTECTION TO ALL PLANS.—Each State shall submit to the Secretary, by not later than 4 years after the date standards are established under subsection (a), a report on the implementation and enforcement of the standards established under subparagraphs (D) and (E) subsection (a)(1) with respect to small employer health benefit plans renewed not later than 4 years after the date such standards were established.

(3) MORE STRINGENT STATE STANDARDS PERMITTED.—A State may implement standards that are more stringent than the standards established under subsection (a).

(4) ENFORCEMENT.—If the Secretary determines that a State has failed to submit a report by the deadline under paragraph (1) or (2) or finds that the State no longer is carrying out its responsibility under the respective paragraph, the Secretary shall notify the State and provide the State a period of 30 days in which to submit such report or to carry out its responsibilities under the respec-

tive paragraph. If, after such 30-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of the standards established under subsection (a) in the State as the Secretary determines to be appropriate. Such standards shall apply to health benefit plans offered or renewed on or after 3 months after the applicable deadlines established under subparagraphs (A) through (C) of subsection (a)(3).

**SEC. 402. PREEMPTION OF STATE BENEFITS MANDATES FOR PLANS THAT MEET CONSUMER PROTECTION STANDARDS.**

(a) FINDING.—Congress finds that health benefit plans offered with respect to small employers affect interstate commerce.

(b) PREEMPTION.—In the case of a small employer health benefit plan that meets the standards with respect to the requirements referred to in subparagraphs (D) and (E) of section 401(a)(1), no provision of State law shall apply that requires the offering, as part of the health benefit plan with respect to such an employer, of any services, category of care, or services of any class or type of provider.

**SEC. 403. REQUIREMENT FOR OFFERING OF BASIC, LOW COST PLAN (MEDEQUITY PLAN).**

(a) IN GENERAL.—Each small employer carrier which makes available in a State any small employer health benefit plan shall make available to each small employer in the State a MedEquity plan (as defined in subsection (b)).

(b) MEDEQUITY PLAN DEFINED.—

(1) IN GENERAL.—In this title, except as provided in paragraph (2), the term ''MedEquity plan'' means a health benefits plan that—

(A) is designed to provide only basic hospital, medical, and surgical benefits, specified under standards under section 401(a)(1)(B), so as to make it affordable to small employers;

(B) is guaranteed issue (as described in subsection (c));

(C) meets the standards established under subparagraphs (D) and (E) section 401(a)(1) (relating to the requirements of sections 404 and 405); and

(D) provides for cost-containment in accordance with the model made applicable under subsection (d) in the State in which the plan is issued.

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—With respect to a carrier that is a Federally-qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), the term ''MedEquity plan'' means a plan of the type described in paragraph (1) but with benefits that are consistent with the requirements for the plans of such an organization under title XIII of such Act. With respect to a carrier that is not such a Federally-qualified health maintenance organization but which is recognized under State law as a health maintenance organization, the term ''MedEquity plan'' means a plan of the type described in paragraph (1) but with benefits that are consistent with the requirements of State law for the plans of such an organization.

(3) REVIEW OF MINIMUM BENEFIT STANDARDS.—The NAIC is requested to periodically review the standards for minimum benefits described in paragraph (1)(A). The NAIC is requested to submit to the Secretary and the Congress its recommendations on changes that should be made in such standards.

(c) GUARANTEED ISSUE FOR MEDEQUITY PLANS.—

(1) IN GENERAL.—Each MedEquity plan in a State—

(A) subject to paragraph (2), must accept every small employer in the State that applies for coverage under the plan;

(B) subject to paragraphs (2) and (3), must accept for enrollment every individual who is a full-time employee (or, in the case of family enrollment with respect to such an employee, the employee's spouse and the employee's dependents who are under 19 years of age or who are full-time students and under 21 years of age) who applies for enrollment on a timely basis; and

(C) subject to paragraphs (2) and (3), may not place any restriction on the eligibility of an individual to enroll, so long as such an individual is a full-time employee or the employee's spouse or dependent described in subparagraph (B).

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of a MedEquity plan offered by a health maintenance organization, the plan shall—

(A) limit the employers that may apply for coverage to those with eligible individuals residing in the service area of the plan,

(B) limit the individuals who may be enrolled under the plan to those who reside in the service area of the plan, and

(C) within the service area of the plan, deny coverage to such employers if the plan demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this subparagraph uniformly to all employers without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

(3) EXCEPTION FOR CERTAIN LATE ENROLLEES.—

(A) IN GENERAL.—Except as provided in this paragraph, paragraph (1)(B) shall not apply to an eligible employee or dependent who fails to enroll in a health benefit plan during an

initial enrollment period, if such period is at least 30 days long.

(B) EXCEPTION FOR THOSE WITH PREVIOUS EMPLOYER COVERAGE.—Subparagraph (A) shall not apply to an individual who—

(i) was covered under another employer health benefit plan at the time of the individual's initial enrollment period,

(ii) stated at the time of initial enrollment period that coverage under another employer health benefit plan was the reason for declining enrollment,

(iii) lost coverage under another employer health benefit plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce, and

(iv) requests enrollment within 30 days after termination of coverage under another employer health benefit plan.

(C) EXCEPTION FOR OPEN ENROLLMENT.—Subparagraph (A) shall not apply to an individual who—

(i) is employed by an employer which offers multiple health benefit plans, and

(ii) elects a different plan during an open enrollment period.

(D) EXCEPTION FOR COURT ORDERS.—Subparagraph (A) shall not apply to a spouse or minor child if a court has ordered coverage be provided for the spouse or child under a covered employee's health benefit plan and request for such coverage is made within 30 days after issuance of such court order.

(d) COST CONTAINMENT STANDARDS.—

(1) DEVELOPMENT OF MODELS.—

(A) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 1 year after the date of the enactment of this Act, models for cost-containment features in MedEquity plans. Such models shall include a managed care plan (described in paragraph (3)) and any combination of such models the NAIC finds appropriate. If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for effective cost-containment. Such review shall be completed within 6 months after the date the models are developed. Unless the Secretary determines within such period that such a model

does not provide effective cost-containment, such remaining models shall serve as the models under this subsection.

(B) CONTINGENCY.—If the NAIC does not develop such models within such period or the Secretary determines that all such models do not provide for effective cost-containment, the Secretary shall inform the NAIC of the specific deficiencies and request the NAIC to develop such models in conformity with paragraph (1).

(2) SELECTION OF COST-CONTAINMENT MODEL BY STATE.—By not later than 2 years after the date of the enactment of this Act, each State shall specify the cost-containment model (developed under paragraph (1)) that will be applied under subsection (a) to MedEquity plans issued in the State.

(3) MANAGED CARE PLAN DEFINED.—For purposes of paragraph (1), the term ''managed care plan'' includes (but is not limited to) any plan that—

(A) arranges with selected providers for the furnishing of health care services,

(B) provides explicit standards for the selection of such providers,

(C) has formal programs for ongoing quality assurance and utilization review, and

(D) provides significant financial incentives for beneficiaries to use providers and procedures associated with the plan.

**SEC. 404. REQUIREMENTS RELATING TO INITIAL WRITING OF POLICIES.**

(a) LIMITATIONS ON TREATMENT OF PRE-EXISTING CONDITIONS.—

(1) IN GENERAL.—A carrier may not impose (or require an employer to impose through a waiting period for coverage under a health benefit policy or similar requirement) a limitation or exclusion of benefits under a small employer health benefit plan relating to treatment of a condition based on the fact that the condition pre-existed the effectiveness of the policy if—

(A) the condition relates to a condition that did not exist within 6 months before the date of coverage under the plan, or

(B) the limitation or exclusion extends over more than 12 months after the date of coverage under the plan.

(2) PREVIOUS SATISFACTION OF PRE-EXISTING CONDITION REQUIREMENT.—

(A) IN GENERAL.—In addition, each carrier shall waive any period applicable to a preexisting condition for similar benefits with respect to an individual to the extent that the individual was covered for the condition under a small employer health benefit plan that was in effect before the date of the enrollment under the carrier's plan.

(B) CONTINUOUS COVERAGE REQUIRED.—Subparagraph (A) shall no longer apply if there is a continuous period of more than 60 days on which the individual was not covered under an employer health benefit plan.

(b) LIMITS ON PREMIUMS.—

(1) LIMIT ON VARIATION OF INDEX RATES BETWEEN BLOCKS OF BUSINESS.—

(A) IN GENERAL.—As a standard under section 402, the index rate for a rating period for any block of business of a small employer carrier may not exceed the index rate for any other block of business by more than 20 percent.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply to a block of business if—

(i) the block is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status,

(ii) the carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the block of business, and

(iii) the block of business is currently available for purchase.

(2) LIMIT ON VARIATION OF PREMIUM RATES WITHIN A BLOCK OF BUSINESS.—For a block of business of a small employer carrier, as a standard under section 402 the premium rates charged during a rating period to small employers with similar demographic or other relevant characteristics (not relating to claims experience, health status, or duration of coverage) for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that block of busi-

ness, shall not vary from the index rate by more than 25 percent of the index rate.

(3) LIMIT ON PERMISSIBLE RATE VARIATIONS.—Subject to paragraphs (1) and (2), as a standard under section 402, a carrier may establish rate variations based on factors such as geography, demography, and industry and plan design.

(4) LIMIT ON TRANSFER OF EMPLOYERS AMONG BLOCKS OF BUSINESS.—As a standard under section 402, a small employer carrier may not involuntarily transfer a small employer into or out of a block of business. A small employer carrier may not offer to transfer a small employer into or out of a block of business unless such offer is made to transfer all small employers in the block of business without regard to demographic characteristics, claim experience, health status, or duration since issue.

(5) DEFINITIONS.—In this subsection:

(A) BASE PREMIUM RATE.—The term ''base premium rate'' means, for each block of business for each rating period, the lowest premium rate charged or which could have been charged under a rating system for that block of business by the small employer carrier to small employers with similar demographic or other

relevant characteristics (not relating to claims experience, health status, or duration of coverage) for health benefit plans with the same or similar coverage.

(B) BLOCK OF BUSINESS.—The term ''block of business'' means, with respect to a carrier, all (or a distinct group of) small employers as shown on the records of the carrier.

(C) RULES FOR ESTABLISHING BLOCKS OF BUSINESS.—For purposes of subparagraph (B)—

(i) a carrier may establish, subject to clause (ii), a distinct group of small employers on the basis that the applicable health benefit plans either—

(I) are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groups of small employers for the carrier,

(II) have been acquired from another carrier as a distinct group, or

(III) are provided through an association with membership of not less

than 100 small employers which has been formed for purposes other than obtaining insurance;

(ii) a carrier may not establish more than 2 groupings under each block of business because the carrier uses managed-care techniques which are expected to produce substantial variation in health care costs; and

(iii) notwithstanding clauses (i) and (ii), a Commissioner of Insurance of a State may, upon application, approve additional distinct groups upon a finding that such approval would enhance the efficiency and fairness of the small employer marketplace.

(D) INDEX RATE.—The term ''index rate'' means, with respect to a block of business, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate for the block.

(c) FULL DISCLOSURE OF RATING PRACTICES.—At the time a carrier offers a health benefit plan to a small employer, the carrier shall fully disclose to the employer rating practices for small employer health benefit plans,

including rating practices for different industries, populations, and benefit designs.

(d) ACTUARIAL CERTIFICATION.—Each carrier shall file annually with the State commissioner of insurance a written statement by a member of the American Academy of Actuaries (or other individual acceptable to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the carrier and methods used by the carrier in establishing premium rates for applicable small employer health benefit plans—

(1) the carrier is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

Each carrier shall retain a copy of such statement for examination at its principal place of business.

(e) REGISTRATION AND REPORTING.—Each carrier that issues any small employer health benefit plan in a State shall be registered or licensed with the State commissioner of insurance and shall comply with any reporting requirements of the commissioner relating to such a plan.

(f) USE OF MINIMUM PARTICIPATION REQUIREMENT.—A carrier may condition issuance, or renewal, of a health benefit plan to a small employer on the enroll-

ment of a minimum number (or percentage) of its full-time employees, in accordance with standards established to carry out this section. Such standards shall require that any such conditions be imposed uniformly on employers of the same size.

**SEC. 405. REQUIREMENTS RELATING TO RENEWAL.**

(a) RENEWABILITY.—A carrier may not cancel a small employer health benefit plan or deny renewal of coverage under such a plan other than—

(1) for nonpayment of premiums,

(2) for fraud or other misrepresentation by the insured,

(3) for noncompliance with plan provisions,

(4) for failure to maintain (in accordance with standards established under section 404(f)) the number of enrollees under the plan at the number (or percentage) required under the plan,

(5) for misuse of a provider network provision, or

(6) because the carrier is ceasing to provide any small employer health benefit plan in a State, or, in the case of a health maintenance organization, in a geographic area.

(b) LIMITATION ON PREMIUM INCREASES.—A carrier may not provide for an increase in the premium charged

a small employer for a small employer health benefit plan in a percentage greater than such percentage as shall be specified in standards referred to in section 401(a)(1)(E). Such standards shall take into account increases in premiums charged for new coverage of small employers under the plan.

(c) LIMITATION ON MARKET REENTRY.—If a carrier terminates the offering of health benefit plans to small employers in an area, the carrier may not offer such a health benefit plan to any small employer in the area until 5 years have elapsed since the date of the termination.

**SEC. 406. ESTABLISHMENT OF REINSURANCE MECHANISMS FOR HIGH RISK INDIVIDUALS.**

(a) ESTABLISHMENT OF STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 1 year after the date of the enactment of this Act, models for reinsurance mechanisms (each in this section referred to as the ''reinsurance mechanism'') for individuals and small employers who are enrolled under a small employer health benefit plan that meets the standards with respect to the requirements referred to in subparagraphs (D) and (E) of section 401(a)(1) and for whom a carrier is at risk of incurring high costs

under the plan. Such models shall include models based on each of the following:

(A) A voluntary prospective reinsurance option.

(B) A retrospective reinsurance option.

(C) An allocation option.

(D) A pooled employee option.

(E) A designated carrier option.

(F) A mandatory reinsurance option.

If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for an effective reinsurance mechanism. Such review shall be completed within 6 months after the date the models are developed. Unless the Secretary determines within such period that such a model is not an effective reinsurance mechanism, such remaining models shall serve as the models under this section.

(2) CONTINGENCY.—If the NAIC does not develop such models within such period or the Secretary determines that all such models do not provide for an effective reinsurance mechanism, the Secretary shall inform the NAIC of the specific deficiencies and request the NAIC to develop such models in conformity with paragraph (1).

(b) REQUIREMENT OF IMPLEMENTATION OF REINSURANCE MECHANISMS.—

(1) IN GENERAL.—By not later than 2 years after the date of the enactment of this Act, each State shall establish one or more reinsurance mechanisms by not later than the deadline specified in section 401(b)(1)(B) of this Act.

(2) DEFAULT.—If the Secretary determines that a State has failed to establish any reinsurance mechanism under paragraph (1), the Secretary shall establish one or more such mechanisms with respect to that State. The authority provided under the previous sentence shall expire upon the Secretary's determination that the State has provided, by law, for establishment of a reinsurance mechanism that meets the requirement of paragraph (1).

(c) CONSTRUCTION.—Nothing in this section shall be construed as to prohibit reinsurance arrangements, whether on a State or regional basis, not required under this section.

**SEC. 407. REGISTRATION OF ALL HEALTH BENEFIT PLANS REQUIRED.**

Notwithstanding any other provision of law, each State commissioner or superintendant of insurance may, under State law, require each employer health benefit plan

(including a self-insured plan) to be registered with such official, if the plan is not otherwise required to be registered or licensed with the official under section 404(e), and to provide the official with such information on the plan as may be necessary to carry out section 406.

**SEC. 408. DEFINITIONS.**

In this subtitle:

(1)(A) The term ''carrier'' means any entity which provides health insurance or health benefits in a State, and includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or employee benefits plan (as defined under the Employee Retirement Income Security Act of 1974), or any other entity providing a plan of health insurance subject to State insurance regulation.

(B) The term ''small employer carrier'' means a carrier with respect to the issuance of a small employer health benefit plan.

(2) The term ''health benefit plan'' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, but does not include—

(A) accident-only, credit, dental, or disability income insurance,

(B) coverage issued as a supplement to liability insurance,

(C) worker's compensation or similar insurance, or

(D) automobile medical-payment insurance.

(2) The term ''NAIC'' means the National Association of Insurance Commissioners.

(3) The term ''Secretary'' means the Secretary of Health and Human Services.

(4)(A) The term ''small employer'' means an entity actively engaged in business which, on at least 50 percent of its working days during the preceding year, employed at least 3, but fewer than 50, full-time employees. For purposes of determining if an employer is a small employer, rules similar to the rules of subsections (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

(B) The term ''full-time employee'' means, with respect to an employer, an individual who normally is employed for at least 30 hours per week by the employer.

(5) The term ''small employer health benefit plan'' means a health benefit plan which provides coverage to one or more full-time employees of a small employer.

(6) The term ''State'' means the 50 States, the District of Columbia, and Puerto Rico.

(7) The term ''State commissioner of insurance'' includes a State superintendent of insurance.

**SEC. 409. PREEMPTION FROM INSURANCE MANDATES FOR QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.**

(a) QUALIFIED SMALL EMPLOYER PURCHASING GROUP DEFINED.—For purposes of this section, an association is a qualified small employer purchasing group if—

(1) the association submits an application to the Secretary of Health and Human Services at such time and in such form as the Secretary may require; and

(2) on the basis of information contained in the application and any other information the Secretary may require, the Secretary determines that—

(A) the association is administered solely under the authority and control of its member employers,

(B) the association's membership consists solely of employers with not more than 100 employees (except that an employer member of the group may retain its membership in the group if, after the Secretary determines that the association meets the requirements of this paragraph, the number of employees of the employer member increases to more than 100),

(C) with respect to each State in which its members are located, the association consists of not fewer than 100 employers, and

(D) at the time the association submits its application, the health benefit plans with respect to the employer members of the association are in compliance with applicable State laws relating to health benefit plans.

(b) PREEMPTION FROM INSURANCE MANDATES.—

(1) FINDING.—Congress finds that employer purchasing groups organized for the purpose of obtaining health insurance for employer members affect interstate commerce.

(2) PREEMPTION OF STATE MANDATES.—In the case of a qualified small employer purchasing group described in subsection (a), no provision of State law shall apply that requires the offering, as part of the

health benefit plan with respect to an employer member of such a group, of any services, category of care, or services of any class or type of provider.

(3) PREEMPTION OF TAXES ON PREMIUMS.—In the case of a qualified small employer purchasing group described in subsection (a), no provision of State or local law shall apply that requires a provider of insurance to pay a tax on premiums received from employer members of the group under a health benefit plan obtained by the group from the insurer for its employer members.

(4) PREEMPTION OF PROVISIONS RELATING TO MANAGED CARE.—In the case of a qualified small employer purchasing group described in subsection (a), the following provisions of State law are preempted and may not be enforced against the health benefit plan with respect to an employer member of such a group:

(A) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a carrier to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(B) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a health benefit plan may require a beneficiary to pay when a nonplan provider is used on a nonemergency basis.

(C) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—(i) Any law that—

(I) prohibits utilization review of any or all treatments and conditions;

(II) requires that such review be made by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered;

(III) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews;

(IV) requires payments to providers for the expenses of responding to utilization review requests; or

(V) imposes liability for delays in performing such review.

(ii) Nothing in clause (i)(II) shall be construed as prohibiting a State from requiring that utilization review be conducted by a licensed health care professional, or requiring that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

(c) EFFECTIVE DATE.—This section shall take effect 60 days after the date of the enactment of this Act.

## Subtitle B—Equalization of Tax Benefits for Self-employed Persons Under Certain Plans

### SEC. 411. EQUALIZATION OF TAX BENEFITS FOR SELF-EMPLOYED PERSONS UNDER CERTAIN PLANS.

(a) INCREASE IN DEDUCTION.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking ''25 percent'' and inserting ''100 percent''.

(b) DEDUCTION MADE PERMANENT.—Subsection (l) of section 162 of such Code is amended by striking paragraph (6).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

## Subtitle C—Managed Care Rights

### SEC. 421. MANAGED CARE RIGHTS.

(a) PREEMPTION OF STATE LAW PROVISIONS.—The following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a carrier to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a health benefit plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

(3) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—Any law that—

(A) prohibits utilization review of any or all treatments and conditions,

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered,

(C) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(D) requires payments to providers for the expenses of responding to utilization review requests, or

(E) imposes liability for delays in performing such review.

Nothing in subparagraph (B) shall be construed as prohibiting a State from (i) requiring that utilization review be conducted by a licensed health care professional or (ii) requiring that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effectiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations as may be appropriate.

## Subtitle D—Study and Report

**SEC. 431. STUDY AND REPORT ON IMPACT.**

(a) STUDY.—The Secretary of Health and Human Services shall provide for a study of the impact of the changes made by this title on—

(1) increasing access to health care,

(2) the number of employees of small employers who do not have health insurance coverage,

(3) the cost of small employer health benefit plans, and

(4) the effectiveness of MedEquity plans.

(b) REPORT.—Not later than 2 years after the first date provided in section 401(b), the Secretary shall submit to Congress a report on the study conducted under sub-

section (a). The Secretary shall include in the report such recommendations for changes in the provisions of this Act as the Secretary deems appropriate.

# TITLE V—ADMINISTRATIVE COST SAVINGS

## Subtitle A—Standardization of Claims Processing

### SEC. 501. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health benefit plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) Uniform claims forms (including uniform procedure and billing codes for uses with such forms and including information on other health benefit plans that may be liable for benefits).

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section—

(1) the Secretary shall take into account the recommendations of current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

(2) the Secretary shall consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) the Secretary shall, to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of the enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of the enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act, and

(B) subsection (a)(3) relating to transmission of information on other services, by such later date as the Secretary may determine it to be feasible.

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

**SEC. 502. APPLICATION OF STANDARDS.**

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 501 with respect to classes of services, that a significant number of claims for benefits for such services under health benefit plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health benefit plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic trans-

mission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health benefit plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health benefit plan may reject any claim subject to the standards adopted under section 501 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health benefit plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 501(a)(1); and

(D) the Secretary may impose a civil money penalty on any provider that knowingly and repeatedly submits claims in violation of such standards or on any health benefit plan (other than a health benefit plan described in

paragraph (2)) that knowingly and repeatedly rejects claims in violation of subparagraph (B), in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan—

(A) that is subject to regulation by a State, and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 501, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall per-

mit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

**SEC. 503. PERIODIC REVIEW AND REVISION OF STANDARDS.**

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 501;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 501, then, in the case of any claim for benefits submitted under a health benefit plan more than the minimum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 502 instead of the standards previously promulgated.

**SEC. 504. HEALTH BENEFIT PLAN DEFINED.**

In this subtitle, the term ''health benefit plan'' has the meaning given such term in section 408(2) and includes—

(1) the medicare program (under title XVIII of the Social Security Act) and medicare supplemental health insurance, and

(2) a State medicaid plan (approved under title XIX of such Act).

# Subtitle B—Electronic Medical Data Standards

**SEC. 511. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.**

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1995, and January 1, 1996, the Secretary shall promulgate standards described in subsection (b) for hospitals concerning electronic medical data.

(2) REVISION.—The Secretary may from time to time revise the standards promulgated under this subsection.

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

(2) A definition of the set of comprehensive data elements, which set shall include for hospitals the standard set of data elements defined under paragraph (1).

(3) Standards for an electronic patient care information system with data obtained at the point of care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

(5) Standards concerning the transmission of electronic medical data.

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 501.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concerning electronic medical data for providers that are not

hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

(2) CONTENTS OF DATA STANDARDS.—The standards promulgated under paragraph (1) for non-hospital providers may include standards comparable to the standards described in paragraphs (2), (4), and (5) of subsection (b) for hospitals.

(d) CONSULTATION.—In promulgating and revising standards under this section, the Secretary shall—

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 515, and with other affected providers, health benefit plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

**SEC. 512. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.**

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1997, subject to paragraph (2), each hospital, as a requirement of

each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 511(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set, in accordance with the standards promulgated under section 511(a).

(b) WAIVER AUTHORITY.—Until January 1, 2000:

(1) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is a small rural hospital, for such period as the hospital demonstrates compliance with such requirements would constitute an undue financial hardship.

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to provide the required data set and executes agreements

with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the Department of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner as such requirements would apply to the hospital if it were participating in the medicare program.

(2) WAIVER.—Such Secretary may waive the application of such requirements to a hospital in the same manner as the Secretary of Health and Human Services may waive under subsection (b) the application of the requirements of subsection (a).

**SEC. 513. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.**

(a) IN GENERAL.—Effective January 1, 2000, if a provider is required under a Federal program to transmit a data element that is subject to a presentation or transmission standard (as defined in subsection (b)), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated under subsection (b) or (c) of section 511, described in paragraph (4) or (5) of section 511(b).

**SEC. 514. LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS ARE IN EFFECT.**

(a) IN GENERAL.—If standards with respect to data elements are promulgated under section 511 with respect to a class of provider, a health benefit plan may not require, for the purpose of utilization review or as a condition of providing benefits under the plan, that a provider in the class—

(1) provide any data element not in the set of comprehensive data elements specified under such standards, or

(2) transmit or present any such data element in a manner inconsistent with the applicable standards for such transmission or presentation.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

**SEC. 515. ADVISORY COMMISSION.**

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator for Health Care Policy and Research, the Secretary of Veterans Affairs, and the Director of the Centers for Disease Control.

(b) FUNCTIONS.—The advisory commission shall monitor and advise the Secretary concerning—

(1) the standards established under this part, and

(2) operational concerns about the implementation of such standards under this part.

(c) STAFF.—From the amounts appropriated under subsection (d), the Secretary shall provide sufficient staff to assist the advisory commission in its activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1994 through 1998 to carry out this section.

# Subtitle C—Development and Distribution of Comparative Value Information

### SEC. 521. STATE COMPARATIVE VALUE INFORMATION PROGRAMS FOR HEALTH CARE PURCHASING.

(a) PURPOSE.—In order to assure the availability of comparative value information to purchasers of health care in each State, the Secretary shall determine whether each State is developing and implementing a health care value information program that meets the criteria and schedule set forth in subsection (b).

(b) CRITERIA AND SCHEDULE FOR STATE PROGRAMS.—The criteria and schedule for a State health care value information program in this subsection shall be specified by the Secretary as follows:

(1) The State begins promptly after enactment of this Act to develop (directly or through contractual or other arrangements with one or more States, coalitions of health insurance purchasers, other entities, or any combination of such arrangements) information systems regarding comparative health values.

(2) The information contained in such systems covers at least the average prices of common health care services (as defined in subsection (d)) and

health insurance plans, and, where available, measures of the variability of these prices within a State or other market areas.

(3) The information described in paragraph (2) is made available within the State beginning not later than one year after the date of the enactment of this Act, and is revised as frequently as reasonably necessary, but at intervals of no greater than one year.

(4) Not later than 6 years after the date of the enactment of this Act the State has developed information systems that provide comparative costs, quality, and outcomes data with respect to health insurance plans and hospitals and made the information broadly available within the relevant market areas.

Nothing in this section shall preclude a State from providing additional information, such as information on prices and benefits of different health benefit plans, available.

(c) GRANTS TO STATES FOR THE DEVELOPMENT OF STATE PROGRAMS.—

(1) GRANT AUTHORITY.—The Secretary may make grants to each State to enable such State to plan the development of its health care value information program and, if necessary, to initiate the implementation of such program. Each State seeking

such a grant shall submit an application therefore, containing such information as the Secretary finds necessary to assure that the State is likely to develop and implement a program in accordance with the criteria and schedule in subsection (b).

(2) OFFSET AUTHORITY.—If, at any time within the 3-year period following the receipt by a State of a grant under this subsection, the Secretary is required by section 522 to implement a health care information program in the State, the Secretary may recover the amount of the grant under this subsection by offset against any other amount payable to the State under the Social Security Act. The amount of the offset shall be made available (from the appropriation account with respect to which the offset was taken) to the Secretary to carry out such section.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to make grants under this subsection, to remain available until expended.

(d) COMMON HEALTH CARE SERVICES DEFINED.—In this section, the term ''common health care services'' includes such procedures as the Secretary may specify and

any additional health care services which a State may wish to include in its comparative value information program.

(e) STATE DEFINED.—In this subtitle, the term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

**SEC. 522. FEDERAL IMPLEMENTATION.**

(a) IN GENERAL.—If the Secretary finds, at any time, that a State has failed to develop or to continue to implement a health care value information program in accordance with the criteria and schedule in section 521(b), the Secretary shall take the actions necessary, directly or through grants or contract, to implement a comparable program in the State.

(b) FEES.—Fees may be charged by the Secretary for the information materials provided pursuant to a program under this section. Any amounts so collected shall be deposited in the appropriation account from which the Secretary's costs of providing such materials were met, and shall remain available for such purposes until expended.

**SEC. 523. COMPARATIVE VALUE INFORMATION CONCERNING FEDERAL PROGRAMS.**

(a) DEVELOPMENT.—The head of each Federal agency with responsibility for the provision of health insurance or of health care services to individuals shall promptly de-

velop health care value information relating to each program that such head administers and covering the same types of data that a State program meeting the criteria of section 521(b) would provide.

(b) DISSEMINATION OF INFORMATION.—Such information shall be made generally available to States and to providers and consumers of health care services.

**SEC. 524. DEVELOPMENT OF MODEL SYSTEMS.**

(a) IN GENERAL.—The Secretary shall, directly or through grant or contract, develop model systems to facilitate—

(1) the gathering of data on health care cost, quality, and outcome described in section 521(b)(4), and

(2) analyzing such data in a manner that will permit the valid comparison of such data among providers and among health plans.

(b) EXPERIMENTATION.—The Secretary shall support experimentation with different approaches to achieve the objectives of subsection (a) in the most cost effective manner (relative to the accuracy and timeliness of the data secured) and shall evaluate the various methods to determine their relative success.

(c) STANDARDS.—When the Secretary considers it appropriate, the Secretary may establish standards for the

collection and reporting of data on health care cost, quality and outcomes in order to facilitate analysis and comparisons among States and nationally.

(e) REPORT.—By not later than 3 years after the date of the enactment of this Act, the Secretary shall report to the Congress and the States on the models developed, and experiments conducted, under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for each fiscal year beginning with fiscal year 1994 to enable the Secretary to carry out this section, including evaluation of the different approaches tested under subsection (b) and their relative cost effectiveness.

## Subtitle D—Additional Standards and Requirements; Research and Demonstrations

### SEC. 531. STANDARDS RELATING TO USE OF MEDICARE AND MEDICAID MAGNETIZED HEALTH BENEFIT CARDS; SECONDARY PAYOR DATA BANK.

(a) MAGNETIZED IDENTIFICATION CARDS UNDER MEDICARE PROGRAM.—The Secretary shall adopt standards relating to the design and use of magnetized medicare identification cards in order to assist health care providers providing medicare covered services to individuals—

(1) in determining whether individuals are eligible for benefits under the medicare program, and

(2) in billing the medicare program for such services provided to eligible individuals.

Such cards shall be designed to be compatible with machines currently employed to transmit information on credit cards. Such cards also shall be designed to be able to be used with respect to the provision of benefits under medicare supplemental policies.

(b) ADOPTION UNDER MEDICAID PLANS.—

(1) IN GENERAL.—The Secretary shall take such steps as may be necessary to encourage and assist States to design and use magnetized medicaid identification cards that meet such standards, for use under their medicaid plans.

(2) LIMITATION ON MMIS FUNDS.—In applying section 1903(a)(3) of the Social Security Act, the Secretary may determine that Federal financial participation is not available under that section to a State which has provided for a magnetized card system that is inconsistent with the standards adopted under subsection (a).

(c) MEDICARE AND MEDICAID SECONDARY PAYOR DATA BANK.—The Secretary shall establish a medicare and medicaid information system which is designed to pro-

vide information on those group health plans and other health benefit plans that are primary payors to the medicare program and medicaid program under section 1862(b) or section 1905(a)(25) of the Social Security Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, a total of $25,000,000 to carry out subsections (a) and (c), including the issuance of magnetized cards to medicare beneficiaries.

**SEC. 532. PREEMPTION OF STATE QUILL PEN LAWS.**

(a) IN GENERAL.—Effective January 1, 1995, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form.

(b) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services may issue regulations to carry out subsection (a). Such regulations may provide for such exceptions to subsection (a) as the Secretary determines to be necessary to prevent fraud and abuse, with respect to controlled substances, and in such other cases as the Secretary deems appropriate.

**SEC. 533. USE OF STANDARD IDENTIFICATION NUMBERS.**

(a) IN GENERAL.—Effective January 1, 1995, each health benefit plan shall—

(1) for each of its beneficiaries that has a social security account number, use that number as the personal identifier for claims processing and related purposes, and

(2) for each provider that has a unique identifier for purposes of title XVIII of the Social Security Act and that furnishes health care items or services to a beneficiary under the plan, use that identifier as the identifier of that provider for claims processing and related purposes.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards established under subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

**SEC. 534. COORDINATION OF BENEFIT STANDARDS.**

(a) REVIEW OF COORDINATION OF BENEFIT PROBLEMS.—Between July 1, 1995, and January 1, 1996, the Secretary shall determine whether problems relating to—

(1) the rules for determining the liability of health benefit plans when benefits are payable under two or more such plans, or

(2) the availability of information among such health benefit plans when benefits are so payable,

cause significant administrative costs.

(b) CONTINGENT PROMULGATION OF STANDARDS.—

(1) IN GENERAL.—If the Secretary determines that such problems do cause significant administrative costs that could be significantly reduced through the implementation of standards, the Secretary shall promulgate standards concerning—

(A) the liability of health benefit plans when benefits are payable under two or more such plans, and

(B) the transfer among health benefit plans of appropriate information (which may include standards for the use of unique identifiers, and for the listing of all individuals covered under a health benefit plan) in determining liability in cases when benefits are payable under two or more such plans.

(2) EFFECTIVE DATE.—The standards promulgated under paragraph (1) shall become effective on a date specified by the Secretary, which date shall be not earlier than one year after the date of promulgation of the standards.

(c) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards promulgated under subsection (b) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty

under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the standards established under subsection (b), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such standards with respect to such plans.

(d) REVISION OF STANDARDS.—If the Secretary establishes standards under subsection (b), the Secretary may revise such standards from time to time and such revised standards shall be applied under subsection (c) on or after such date (not earlier than 6 months after the date the revision is promulgated) as the Secretary shall specify.

**SEC. 535. RESEARCH AND DEMONSTRATIONS.**

(a) DEMONSTRATIONS AND RESEARCH ON MONITORING AND IMPROVING PATIENT CARE.—

(1) The Secretary shall provide grants to qualified entities to demonstrate (and conduct research

concerning) the application of comprehensive information systems—

(A) in continuously monitoring patient care, and

(B) in improving patient care.

(2) To make grants under this subsection, there are authorized to be appropriated from the Federal Hospital Insurance Trust Fund $10,000,000 for each fiscal year (beginning with fiscal year 1995 and ending with fiscal year 1999).

(b) COMMUNICATION LINKS.—

(1) The Secretary may make grants to at least two, but not more than five, community organizations, or coalitions of health care providers, health benefit plans, and purchasers, to establish and document the efficacy of communication links between the information systems of health benefit plans and of health care providers.

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

(c) REGIONAL OR COMMUNITY BASED CLINICAL INFORMATION SYSTEMS.—

(1) The Secretary may make grants to at least two, but not more than five, public or private non-profit entities for the development of regional or community-based clinical information systems.

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

(d) AMBULATORY CARE DATA SETS.—

(1) The Secretary may make grants to public or private non-profit entities to develop and test, for electronic medical data generated by physicians and other entities (other than hospitals) that provide health care services—

(A) the definition of a comprehensive set of data elements, and

(B) the specification of, and manner of presentation of, the individual data elements of the set under subparagraph (A).

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

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